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 J. Richards,

Petitioner,

vs.

NO: 12 WC 19189

18IWCC0270

Curran Group, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 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.

18IWCC0270

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: MAY 2 - 2018
TJT:yl
o 5/1/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RICHARDS, HENRY J
Employee/Petitioner

Case# **12WC019189**

12WC019190

CURRAN GROUP INC
Employer/Respondent

18IWCC0270

On 3/4/2016, 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:

0800 BARRY E BLUMENFELD & ASSOC
3424 W 26TH ST
SUITE 202
CHICAGO, IL 60623

1109 GAROFALO SCHREIBER HART ETAL
DEREK STORM
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

18IWCC0270

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

HENRY J. RICHARDS,
Employee/Petitioner

v.

CURRAN GROUP, INC.,
Employer/Respondent

Case # **12** WC **19189**

Consolidated case: **12 WC 19190**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **June 9, 2015** and **September 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 31, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,017.36**; the average weekly wage was **$654.18**.

On the date of accident, Petitioner was **64** years of age, **married** with **0** dependent children.

Respondent is not liable for the medical expenses claimed by Petitioner.

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 **$7,044.46** under §8(j) of the Act.

ORDER

PETITIONER'S APPLICATION FOR BENEFITS IS DENIED FOR FAILURE TO PROVE THAT HE SUSTAINED AN ACCIDENTAL INJURY THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT BY RESPONDENT AND FOR FAILURE TO PROVE THAT HIS CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE CLAIMED ACCIDENT.

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

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

Arbitrator Steven J. Fruth

February 29, 2016
Date

ICArbDec p. 2

MAR 4 - 2016

HENRY J. RICHARDS v. CURRAN GROUP, INC.
12 WC 19189; consolidated with 12 WC 19190

INTRODUCTION

This matter proceeded to hearing on June 9, 2015 and September 30, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute?; and ***L:*** What is the nature and extent of the injury?

Petitioner, Kevin Cantrell, David Lewis, and Christian Jostlein testified at trial. Both parties submitted exhibits in evidence. Petitioner's wife, Cathy Richards, was called as a witness but she was unable to complete her testimony. Therefore the Arbitrator disregarded what testimony she gave.

STATEMENT OF FACTS

On March 31, 2012 Petitioner was employed by Respondent as a locomotive technician. This required him to service the locomotives and make sure that they were properly attached to the trains in the yard.

During his testimony Petitioner periodically refreshed his memory from notes he had made. He testified that his memory "was not the best".

Petitioner refreshed his memory that on March 31, 2012 while blowing sand into a locomotive through a pipe, the valve did not work properly and the sand did not discharge from the pipe. He had to pick up the pipe which contained the sand which was very heavy. While doing so, he felt a snap in his neck and pain in his neck and left shoulder.

On cross examination Petitioner acknowledged that when he was hired by Respondent in September 2007 he was issued an Employee Policy Handbook (RX #1) and the Safety Rulebook (RX #2). The rules require that work injuries are to be reported to a supervisor immediately. Petitioner admitted that before each workday there were regular safety meetings during which the company rule regarding the reporting of work related injuries was generally covered. Petitioner admitted that he knew the rule that required immediate reporting of work injuries. He acknowledged that he could report an injury to anyone in the supervisory chain: Kevin Cantrell or David Lewis or the safety manager, Christian Jostlein.

On cross-examination Petitioner admitted that he did not immediately report his accident to his team leader, David Lewis, or operations manager, Kevin Cantrell, or, to safety manager, Christian Jostlein, on the date of the accident. After refreshing his memory Petitioner testified that he notified Mr. Cantrell of his accident by telephone on April 6, 2012.

On March 31, 2012 Petitioner's shift began at 6:00 a.m. and ended at 6:00 p.m. Petitioner testified that the accident occurred at approximately 12:00 noon. Petitioner continued to perform his normal job duties and finished his shift. He explained that his left shoulder injury did not seem serious at the time but got worse over the next few days. That was why he delayed in reporting his injury. After completing his shift, Petitioner went home. He did not seek any medical care on March 31, 2012.

Petitioner continued to work through April 6, 2012. He did not report his injury to any supervisor from March 31 through April 5. He first sought medical care on April 4, 2012 at MacNeal Memorial Hospital (PX #1), where he was x-rayed. He admitted on cross examination that this medical care was prior to the date on which he said he reported his accident, which was April 6, 2012. Petitioner also testified that no one from the company sent him to MacNeal and it was his own choice to seek medical care at that facility.

The records of Dr. Robert Kash (RX #6) note Petitioner's consultation on April 6. Dr. Kash noted Petitioner's report that he had been in the ER "yesterday" for left arm pain. Dr. Kash advised Petitioner to follow-up with Dr. Hejna.

Petitioner testified that he contacted Mr. Cantrell, the operations manager, by telephone on April 6, 2012. He could not recall whether he contacted Mr. Cantrell from the site trailer, or from his truck, or from his home. Petitioner testified that he told Mr. Cantrell that due to his neck pain he would be unable to work the following Sunday. He could not recall Mr. Cantrell's response. He testified that he did not tell Mr. Cantrell that his injury was not related to work.

Also on April 6, 2012 Petitioner sought medical care with chiropractor Chris Edginton of Midwest Medicorp (PX #2). Petitioner testified that he was referred to Midwest by a friend. Petitioner received chiropractic care from April 6 through April 9, 2012 and from April 25 through May 19, 2012. Petitioner's registration form noted his report that he damaged a muscle in his left shoulder when lifting heavy equipment at work. He marked Insurance Data: "Major Medical" rather than "Work Comp". Petitioner also checked boxes that the visit was not due to an accident, and that it was a "work" accident but was not reported. Dr. Edginton wrote a Work Status Report on April 7 for Petitioner to be off work from April 7 to April 14, 2012.

On April 6, 2012 Dr. Edginton wrote a Letter of Medical Necessity addressed "To Whom It May Concern" letter summarizing Petitioner's history, subjective complaints, and findings on examination. Dr. Edginton noted Petitioner's report that he felt stabbing pain in his left upper mid back near the shoulder when he lifted a sand filled pipe on March 31, 2012. When his pain got worse Petitioner reported that he phoned

Dr. Kash on April 4, who referred him to MacNeal Hospital. On examination Dr. Edginton found reduced strength and range of motion in the left shoulder. In his Letter of Medical Necessity Dr. Edginton diagnosed neck pain and shoulder pain with a fair prognosis and "unknown" for when MMI might be attained.

On April 7, 2012 Petitioner had two telephone conversations with operations manager Kevin Cantrell. The second phone call on April 7 was a three-way conversation with safety manager Christian Jostlein, Petitioner, and Mr. Cantrell. Petitioner denied that he said his injury was not work related in those April 7 conversations. He did not remember if Mr. Cantrell said if his injury was not work related he should apply for short term disability.

Petitioner testified that Mr. Cantrell came to his home on April 9, 2012 with papers that he thought was the short term disability application. Petitioner said he was in a lot of pain and implied he did not understand what he was reading. He did not remember signing the papers. Petitioner's wife was present during Mr. Cantrell's visit.

On April 10, 2012 Petitioner spoke by telephone with Valerie in Human Resources department at Respondent. However, he could not recall the substance of that conversation.

On April 11, 2012 Petitioner saw Dr. Michael Hejna of Orthopaedic Associates of Riverside (PX #3 & RX #7). There is registration note and an off work note for April 11 but no clinical notes for that date. Petitioner saw Dr. Hejna again on April 18. Petitioner was still complaining of significant left shoulder pain. The April 16 MR arthrogram (ordered by Dr. Hejna according to the report) was reviewed and the findings of SLAP lesion and rotator cuff tendinitis were confirmed. Petitioner's range of left shoulder motion was limited due to pain. Dr. Hejna suggested arthroscopic management.

Petitioner returned to Dr. Hejna on May 22 for follow up on the left shoulder after completing therapy. At which time Petitioner stated that he was doing well with respect to his left shoulder but had carpal tunnel symptoms. Dr. Hejna released Petitioner to return to work without restriction effective May 26, 2012 at petitioner's request.

Petitioner returned as a locomotive technician without restrictions on May 26, 2012. He testified that he worked with a lot of pain. He continued to work at full duty through July 12, 2012, when he was laid off. Petitioner then applied for unemployment compensation benefits. Petitioner admitted that he had to certify to the State of Illinois that he was ready, willing, and able to work and actively seeking employment.

After his lay-off Petitioner began working as a bus driver for Grand Prairie sometime in 2012. To hold the bus driver's position with Grand Prairie, Petitioner needed a commercial driver's license (CDL). Petitioner testified that he has been continually employed as a bus driver for Grand Prairie up to the day of trial. To continue in this employment Petitioner testified that he had to pass a physical exam to

renew his CDL license. He did undergo the physical, passed the physical, and was certified for his CDL.

Petitioner was examined by Dr. Nikhil Verma pursuant to §12 of the Act on September 16, 2013.

During his employment with Respondent Petitioner was covered by a group health insurance policy through Blue Cross/Blue Shield.

At present Petitioner still has left shoulder pain. The pain disrupts his sleep. He can't pick up his 5 year old grandson due to his shoulder pain.

Kevin Cantrell

Kevin Cantrell testified on behalf of Respondent. Mr. Cantrell testified that beginning in 2005 and continuing through the summer of 2012 he was the operations manager for Respondent. As the operations manager, his overall job duties required him to ensure that the equipment was in running order, that all employees understood their jobs, and overall cite operations. This included knowing Respondent's safety rules.

Mr. Cantrell testified that all employees were instructed to immediately report an accident or near miss injury to their supervisor. This training commenced during the hiring process and continued on a daily basis thereafter. All employees received a copy of the Company Handbook (RX #1) and the Safety Rules (RX #2) which outlined the rule regarding the reporting of work related accidents or injuries. Petitioner signed an acknowledgement of receipt to the Handbook and the Safety Rules on September 18, 2007 (RX #3). Mr. Cantrell further testified that regular safety meetings were held from the date of Petitioner's hire in 2007 to the date of the claimed accident on March 31, 2012. During the safety meetings, the rule regarding the reporting of work related injuries was routinely discussed.

Mr. Cantrell was the operations manager for Respondent in March 2012. He would have been the person Petitioner would report a work accident to. Petitioner did not report a work accident to him on March 31, 2012. Mr. Cantrell would have completed the necessary documentation to memorialize the reporting of a work accident as required by the company procedure if Petitioner had reported a work accident.

As the operations manager for Respondent, Mr. Cantrell was familiar with the job duties of a service technician. Those duties included a pre-trip inspection of equipment. The pre-trip inspection of the vehicle would include the vehicle and all components on the vehicle. The purpose of the pre-trip inspection was to make sure that the vehicle and all components were working properly. After the completion of the pre-trip inspection, during the same shift the service technician had to complete a document entitled Driver's Vehicle Inspection Report (DVIR).

If a service technician noticed anything wrong with the vehicle or that any of the equipment was not working properly during the pre-trip inspection the technician

would note this on the DVIR and also would complete a document entitled Vehicle Repair Request form (VRR).

On March 31, 2012 and April 1, 2012 Petitioner completed pre-trip inspections of the vehicles to which he was assigned. Respondent's Exhibit #13 is the DVIR dated 3/31/12 and signed by Petitioner for Tractor/Truck No. 10060. Petitioner noted that condition of the vehicle was satisfactory. Respondent's Exhibit # 14 is the DVIR dated 4/1/12 and signed by Petitioner for Tractor/Truck No. 10062. Petitioner noted that condition of the vehicle was satisfactory.

Mr. Cantrell testified that if there was a defect in the vehicle or any component of the vehicle, then the service technician was required to complete a document entitled VRR form. The VRR could be completed by the service technician either after the pre-trip inspection or after using the vehicle during the course of a work day during which he noted a defect or problem in the vehicle or its components. The VRR Form would then be provided by the service technician to the company so that the vehicle could be repaired. The VRR forms are kept in the normal course of the company for documentation regarding repairs. Mr. Cantrell testified that there was no record of Petitioner completing a VRR for either of the vehicles he worked on March 31, 2012 or April 1, 2012.

Petitioner did telephone Mr. Cantrell on April 6, 2012. Petitioner stated that his shoulder was hurting and he would need someone to cover his shift. Mr. Cantrell testified that he expressly asked Petitioner whether the condition in his shoulder was due to a work accident and Petitioner answered that it was not. Petitioner went on to say that he would be seeking the care of his personal doctor for his shoulder.

Mr. Cantrell stated that had Petitioner informed him that the condition in his shoulder was due to a work accident he would have followed the company procedure and completed the necessary documentation.

On the next day, April 7, Mr. Cantrell testified that he had two separate telephone conversations with Petitioner. The first was when Petitioner called Mr. Cantrell. Petitioner reported that he was on muscle relaxers and would probably be off work for at least one week. Mr. Cantrell stated that he would get Petitioner's shift covered for him. Mr. Cantrell further testified that he instructed to Petitioner to call him back that same day. He also testified that during the first conversation on April 7, 2012 that Petitioner did not say his left shoulder complaints were due to a work accident.

After the first telephone conversation with Petitioner on April 7, Mr. Cantrell then contacted safety director Christian Jostlein. Mr. Cantrell stated that the reason for contacting Mr. Jostlein was to have a "witness" to any further conversations with Petitioner. Mr. Cantrell then set up a conference call between Petitioner, Mr. Jostlein, and himself.

During the conference call with Petitioner and Mr. Jostlein and himself on April 7, 2012 Mr. Cantrell asked Petitioner whether the condition in his shoulder was due to a

work related injury. Mr. Cantrell testified that Petitioner stated that it was not. Mr. Cantrell reminded Petitioner that if it was a work related injury they would need to complete the "work-comp papers". Mr. Cantrell asked Petitioner whether they would need to complete these papers and again, Petitioner stated that it was not a work related injury.

Mr. Cantrell then testified that Petitioner then asked about using vacation time to cover his lost time. In response, Mr. Cantrell told Petitioner could use his vacation time, but if he was going to be off work for more than 1 week he might be eligible for short term disability (STD) benefits. Mr. Cantrell testified that Petitioner seemed excited to hear this and requested the STD paperwork.

At the conclusion of the conference call Mr. Jostlein once again asked Petitioner whether the condition was due to a work related injury. Petitioner again stated that the condition in his shoulder was not due to a work related injury.

After the conference call with Petitioner on April 7, 2012 Mr. Cantrell contacted Valerie Lynch of HR to obtain the STD documents. Ms. Lynch was out on vacation, so Mr. Cantrell obtained the documents from Danielle Gibbons.

On April 9, 2012 Mr. Cantrell phoned Petitioner at his home. He informed Petitioner that he had the STD paperwork and asked Petitioner wanted pick the paperwork up at the company. Petitioner stated that he was on medication and did not feel comfortable driving a vehicle. Mr. Cantrell then delivered the STD paperwork to Petitioner's home alter that day. Mr. Cantrell testified that during this visit Petitioner did not report that his shoulder problem was from a work related accident.

Mr. Cantrell testified that he first learned on April 10, 2012 that Petitioner was claiming a work injury. Mr. Cantrell then began completing the company documentation for a work related injury. The documentation included EMPLOYEE ACCIDENT/NEAR MISS EVALUATION REPORT (RX #15) and WITNESS/INJURED INCIDENT REPORT (RX #16). RX #16 was completed by David Lewis.

Mr. Cantrell testified that he telephoned Petitioner by on April 12, 2012 in order to get the information needed to complete the April 12, 2012 Employee's Accident Report (RX #15). The information contained on RX #15 was the information that was provided him by Petitioner during their telephone conversation. Mr. Cantrell documented Petitioner's statement that it was a malfunction on the valve on truck 10062 on March 31, 2012 that caused the injury to his left shoulder.

Mr. Cantrell noted the discrepancy between the DVIRs, RX #13 and RX #14, and Petitioner's statement during the April 12 telephone conversation.

Mr. Cantrell testified that Petitioner did return to work for Respondent as a service technician on May 26, 2012. Petitioner continued to perform all of his normal job duties from this date through July 12, 2012. During this period of time Petitioner did not ask for relief from any job assignments due to pain or problems involving his left shoulder.

David Lewis

Mr. Lewis was called to testify by Respondent. He testified that on March 31, 2012 he was employed by Respondent as a team lead. In this position he was familiar with the rules regarding reporting a work related injury in effect on that date. Mr. Lewis testified that the rules required all work related injuries to be immediately reported to the team leader or supervisor. Once an employee reported a work related injury it was incumbent upon the team leader or the supervisor to complete the Employee Accident Report; Supervisor's Accident Report; and Supervisor's Incident Report completed.

Mr. Lewis was the team leader for Petitioner on March 31, 2012. As the team lead he would have been one of the individuals to whom Petitioner could have reported a work related accident. He testified that Petitioner did not report a work related accident to him on March 31, 2012.

Mr. Lewis worked with Petitioner from March 31 through April 6, 2012. During that time Petitioner performed all of the normal job duties of a locomotive technician. At no time during the period from March 31 through April 6, 2012 did Petitioner report a work related injury involving his left shoulder to Mr. Lewis. At no time did he beg off any job assignments due to pain or problems involving his left shoulder.

On April 8, 2012 Mr. Lewis was contacted by operations manager Kevin Cantrell, who stated that Petitioner would be out of work. The next day, April 9, Mr. Lewis contacted Petitioner. At that time Petitioner stated that his shoulder was sore. Mr. Lewis asked Petitioner if he had hurt himself at work and whether it was a work related injury. Petitioner stated that the condition in his left shoulder was not due to a work related injury.

Mr. Lewis learned later that Petitioner was claiming that the condition in his left shoulder was due to a work related injury. Mr. Lewis then began completing the required documents including the Injured Incident Report (RX #16).

Petitioner returned to work on May 26, 2012 and continued working for the respondent through July 12, 2012. During this time Mr. Lewis worked with him and at no time did Petitioner complain of any pain or problems involving his left shoulder. He was able to and did perform all of the normal employment activities of a locomotive service technician for the respondent during the aforesaid period of time.

Christian Jostlein

On July 27, 2010 Mr. Jostlein was employed with Respondent as the safety manager/director. In this position he was familiar with the rules for reporting work related injuries. The rule required all employees to immediately report a work related injury to their supervisor. Once a work related accident was reported, it was incumbent upon the team leader and supervisor to have the employee complete the Employee Accident Report and for the supervisor and operations manager to complete a Supervisor's Accident Report and a Supervisor's Incident Report.

Mr. Jostlein testified that he was contacted by operations manager Kevin Cantrell by telephone on April 7, 2012. The telephone conversation was only between Mr. Cantrell and Mr. Jostlein. During that conversation Mr. Cantrell stated that Petitioner was off work due to a health issue and that the condition was not work related. Mr. Cantrell stated that he wished to set up a conference call with Petitioner so that Mr. Jostlein could confirm Petitioner's report that his medical condition was not work related. Mr. Jostlein agreed to participate in the conference call.

Later on April 7, 2012 there was a telephone conference call between Petitioner, Mr. Cantrell, and Mr. Jostlein. Mr. Jostlein testified that Mr. Cantrell asked Petitioner if the condition in his shoulder was due to a work related injury, and in response Petitioner stated that it was not. Mr. Cantrell then asked Petitioner if he had sought medical care for his shoulder and if so, what had he told his doctor regarding the condition in his shoulder. Petitioner responded that he told his doctor that it was not work related.

Mr. Cantrell then stressed the importance to Petitioner of specifying whether it was work related or not work related due to the different type of paperwork that had to be completed by Mr. Cantrell. Once again, Petitioner stated that the condition was not work related. At that point in time Mr. Cantrell then outlined the short term disability policy in effect with Respondent and asked whether Petitioner would like to pursue STD benefits. Mr. Jostlein testified that Petitioner was "very positive" about pursuing STD benefits.

At the conclusion of the conference call Mr. Jostlein testified that he directly asked Petitioner if the condition in his shoulder was due to a work related injury. Petitioner again said that condition was not due to a work related injury.

Petitioner did not move to offer rebuttal testimony after Respondent rested with its witnesses.

Dr. Nikhil Verma (RX #8)

The evidence deposition of Dr. Nikhil Verma on March 4, 2015 was admitted in evidence as Respondent's Exhibit #8.

Dr. Verma is a board certified orthopedic surgeon. In addition, Dr. Verma is certified in conducting AMA Impairment Evaluations and providing AMA Impairment Ratings. Dr. Verma examined Petitioner's left shoulder pursuant to §12 of the Act on September 13, 2013. In addition to his examination of Petitioner Dr. Verma reviewed various medical records of Petitioner: Dr. Kash, MacNeal Memorial Hospital, and Dr. Hejna. Dr. Verma also reviewed x-rays and the MRI arthrogram. He prepared a report on September 13 which was offered in evidence without objection at the time of the deposition. The report was not attached to the deposition transcript.

Petitioner gave a history that his shoulder injury occurred when he was lifting a heavy sand pipe. It was required to lift the pipe overhead. He felt a shoulder pain

during this maneuver which increased over 4-5 days. Petitioner reported that he had been recommended to have surgery on the left shoulder. At the examination Petitioner complained of continued pain in the left shoulder and in the neck. On examination he had a full range of motion but complained of pain over the biceps and anterior shoulder. Dr. Verma noted mild weakness but also noted the absence of atrophy. On review of the MRI study of April 16, 2012 Dr. Verma found normal age-related changes in the rotator cuff and with the acromioclavicular joint. Essentially he found arthritis. He found no evidence of a labral tear or degeneration.

Dr. Verma noted that Dr. Hejna had released Petitioner to return to work on May 22, 2012. Dr. Verma found that petitioner had attained MMI. His final diagnosis was biceps tenosynovitis resulting in a 3% impairment of the upper extremity. Dr. Verma took note of petitioner's lack of active medical care for more than one year in a coming to his opinions.

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 failed to prove that he sustained and accidental injury that arose out of and in the course of his employment by Respondent.

Petitioner's credibility as a witness was highly questionable. He readily admitted that his memory "was not the best". Petitioner's medical records demonstrate that he was also a poor historian; such as reported to Dr. Kash on April 6 that he had been in the ER "yesterday", when it was actually 2 days before on April 4. He repeatedly refreshed his memory with reference to a diary he maintained.

Petitioner's medical records from Dr. Hejna, Dr. Kash, and MacNeal Memorial Hospital following the claimed injury on March 31, 2012 do not document that Petitioner reported that he injured his left shoulder while at work. The only record of Petitioner's report that he injured his left shoulder at work was in Dr. Edginton's April 6, 2012 Letter of Medical Necessity "To Whom It May Concern" letter. This letter was clearly written for purposes of litigation and was therefore disregarded by the Arbitrator.

Petitioner did not check the "Work Comp" box on the Midwest Medicorp registration form. Further, Petitioner marked "no" in response to a question if he had had an x-ray, CT scan, or MRI in the previous 28 days. The records of MacNeal Memorial Hospital (RX #1) and Petitioner's direct testimony confirmed that he had been x-rayed. These chart entries demonstrate Petitioner's significantly poor memory.

Petitioner testified that he did not ever say he did not know what caused his left shoulder problem. He testified that he did not say to anyone that his shoulder left problem was not related to work. Kevin Cantrell, David Lewis, and Christian Jostlein testified clearly and credibly that Petitioner specifically stated that his left shoulder problems were not work related and, further, he did not know how his shoulder was

injured. In addition, Mr. Lewis and Mr. Cantrell testified credibly from March 31 through April 6, 2012 Petitioner did not mention a work-related accident or injury.

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, the lesser number of witnesses, namely Petitioner, on the proposition that Petitioner sustained a work-related accidental injury was not credible. In addition, there were numerous inconsistencies and omissions in Petitioner's evidence. DVIRs, RX #15 and RX#16, contradict Petitioner's testimony that he was injured while servicing a train locomotive. Further, except for Midwest Medicorp, there was no documentation that Petitioner injured his left shoulder on the job. Finally, Petitioner's ability to work at full duty for a week following the claimed accident without complaining that he hurt his shoulder at work belies that claim that he was hurt at work.

Petitioner's claim that he was injured in an accident that arose out of and in the course of his employment by Respondent rests on his credibility. Although Petitioner denied during his direct testimony that he denied stating that his injury was not work related the Arbitrator takes note that Petitioner passed up one last opportunity to rebut the testimonies of Mrs. Cantrell, Lewis, and Jostlein. On faced with such testimony would normally avail themselves of rebuttal.

In light of all the evidence Petitioner's credibility is so questionable that he could not bear his burden of proof. Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment.

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 the accident. The Arbitrator previously found that Petitioner was not credible. Petitioner could not bear his burden of proving causation based on his lack of credibility.

The only direct evidence of causation offered by Petitioner was the Letter of Medical Necessity by Dr. Edginton contained within Petitioners Exhibit #2. However the Arbitrator disregarded that letter since it had clearly been generated for the purposes of litigation. Other medical records of Petitioner could have, through circumstantial evidence, established causation. However the medical records of MacNeal Memorial Hospital, Dr. Kash, and Dr. Henja, were silent as to any report by Petitioner that he had had been injured at work.

Based on such scant evidence the Arbitrator cannot infer that causation was established.

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 light of the Arbitrator's previous findings that Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment and that he failed to prove that his condition of ill-being is causally related to the claimed work accident this issue is moot.

However, the Arbitrator does note that Petitioner exceeded the permitted number of choices of healthcare providers, as provided in §8(a) of the Act. Petitioner testified that he chose his healthcare providers after his claimed accidental injury. MacNeal Memorial Hospital was Petitioner's first choice for medical care. Dr. Kash appears to have been his second choice on April on April 6, 2012. Dr. Kash apparently referred Petitioner back to Dr. Hejna. However, Dr. Edginton at Midwest Medicorp appears to have been Petitioner's third choice.

Therefore, Respondent would not be liable for payment of Dr. Edginton at Midwest Medicorp professional services.

K: What temporary benefits are in dispute?

In light of the Arbitrator's previous findings that Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment and that he failed to prove that his condition of ill-being is causally related to the claimed work accident this issue is moot.

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

In light of the Arbitrator's previous findings that Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment and that he failed to prove that his condition of ill-being is causally related to the claimed work accident this issue is moot.

Steven J. Fruth, Arbitrator

February 29, 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 J. Richards,

Petitioner,

vs.

NO: 12 WC 19190

18IWCC0271

Curran Group, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 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: MAY 2 - 2018
TJT:yl
o 5/1/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RICHARDS, HENRY J
Employee/Petitioner

Case# **12WC019190**

12WC019189

CURRAN GROUP INC
Employer/Respondent

18IWCC0271

On 3/4/2016, 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:

0800 BARRY E BLUMENFIELD & ASSOC
3424 W 26TH ST
SUITE 202
CHICAGO, IL 60623

1109 GAROFALO SCHREIBER HART ETAL
DEREKM STORM
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS 18IWCC0271

)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

HENRY J. RICHARDS,
Employee/Petitioner

v.

CURRAN GROUP, INC.,
Employer/Respondent

Case # **12** WC **19190**

Consolidated case: **12 WC 19189**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Steven Fruth, Arbitrator of the Commission, in the city of **Chicago**, on **June 9, 2015** and **September 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 27, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$32,184.36**; the average weekly wage was **$618.93**.

On the date of accident, Petitioner was **62** years of age, **married** with **0** dependent children.

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

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

ORDER

PETITIONER'S APPLICATION FOR ADJUSTMENT OF CLAIM IS DENIED FOR PETITIONER'S FAILURE TO PROVE THAT HE SUSTAINED AN ACCIDENTAL INJURY THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT BY RESPONDENT, AND FOR HIS FAILURE TO PROVE THAT HE GAVE TIMELY NOTICE TO RESPONDENT OF HIS CLAIMED INJURY, AND HIS FAILURE TO PROVE THAT HIS CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE CLAIMED ACCIDENT.

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.

Steven J. Fruth

February 29, 2016

MAR 4 - 2016

Steven J. Fruth, Arbitrator Date

HENRY J. RICHARDS v. CURRAN GROUP, INC.
12 WC 19190, consolidated with 12 WC 19189

INTRODUCTION

This matter proceeded to hearing on June 9, 2015 and September 30, 2015before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; and ***L:*** What is the nature and extent of the injury?

Petitioner, Kevin Cantrell, David Lewis, and Christian Jostlein testified at trial. Both parties submitted exhibits in evidence.

STATEMENT OF FACTS

On July 27, 2010 Petitioner was employed by Respondent as a locomotive technician. This required him to service the locomotives before they are attached to the trains in the yard.

During his testimony Petitioner periodically refreshed his memory from notes he had made. On cross-examination he admitted that his memory was not the best.

Petitioner testified that on July 27, 2010, while climbing down from a locomotive he missed a step. He was working alone. His right arm was holding onto a rung at the top of the locomotive and his body weight was pulled down on his right shoulder. His right shoulder hurt immediately.

On cross-examination Petitioner testified that his shift began at 6:00 p.m. and ended at 6:00 a.m. He said his accident occurred sometime between 12:00 a.m. to 3:00 a.m. Petitioner testified he continued working for 3 to 6 hours performing his normal duties as a locomotive technician.

On cross-examination Petitioner admitted that he did not report his accident of July 27, 2010 to his team leader, David Lewis; or to his supervisor Kevin Cantrell; or, to the safety manager Christian Jostlein, on the date of accident as required by the Employee Policy Handbook (RX #1) and the Safety Rulebook (RX #2). The rules require that work injuries are to be reported to a supervisor immediately. Petitioner admitted that before each workday there were regular safety meetings during which the company rule regarding the reporting of work related injuries was generally covered. Petitioner admitted that he knew that if he had a work related injury he was to immediately report it to his supervisor.

On July 27, 2010 Petitioner was working at the train yard in West Chicago, Illinois. After completing his shift that day he left the train yard and drove to his home on 63rd Place in Chicago, Illinois. The entire trip was over 40 miles one way. At no time during this trip did he stop to seek medical care for the alleged injury to his right shoulder.

He testified that he notified Kevin Cantrell, his supervisor, of the accident in the week of August 4th, although he could not recall the precise date. He described how the accident happened. Mr. Cantrell asked if he could work and Petitioner said he could work with his pain. He did not file an accident report until October 11, 2010. On cross-examination he affirmed his handwriting and signature on the Employee Accident/Near Miss Evaluation Report (RX #5). He acknowledged that he wrote in that his accident occurred August 29, 2010. Petitioner acknowledged that the date of accident he entered on RX #5 is inconsistent with the Application for Adjustment he filed with the Illinois Workers' Compensation Commission. Petitioner admitted that it would have been impossible for him to have given notice of an August 29, 2010 accident to Mr. Cantrell during the week of August 4, 2010.

Petitioner testified that he continued to work his regular job from July 28 to October 10, 2010. He further testified that he continued to work as a locomotive technician without time off for his right shoulder injury until March 31, 2012.

Petitioner initially testified that the first medical care he received was from MacNeal Memorial Hospital. He later corrected himself and testified that he first sought care from Dr. Kash on July 29. On cross-examination Petitioner testified that he told Dr. Kash that his right shoulder problems began one year before.

Petitioner then sought care with Dr. Michael Hejna on September 3, 2010. On cross-examination Petitioner acknowledged he told Dr. Hejna that he had first injured his right shoulder 2 years before.

Petitioner admitted on cross-examination that he used his Blue Cross/Blue Shield for his medical care.

Petitioner testified that he had right shoulder pain at the trial. He denied that he had injured his right shoulder within 10 years of 2010.

Kevin Cantrell

Kevin Cantrell was called as a witness by Respondent. Mr. Cantrell testified that beginning in 2005 and continuing through the summer of 2012 he was the operations manager for Respondent. As the operations manager, his overall job duties required him to ensure that equipment was in running order, that all employees understood their jobs, and overall site operations. This included knowing the safety rules in effect.

Mr. Cantrell testified that all employees were trained to immediately report an accident or near miss injury to their supervisor. This training began at hiring and continued on a daily basis thereafter. All employees received a copy of the Company

Handbook and the Safety Rules, which outlined the rule that work related accidents or injuries are to be reported immediately. Mr. Cantrell further testified that regular safety meeting were held from the date of the petitioner's hire in 2007 to the date of the alleged accident on July 27, 2010. During the safety meetings, the rule regarding the reporting of work related injuries was routinely discussed.

On July 27, 2010 Mr. Cantrell was the operations manager for Respondent. He would be the person to whom Petitioner would have reported a work accident. Petitioner did not report a work accident to him on this date. Had Petitioner done so, Mr. Cantrell would have completed the necessary paperwork to report a work related accident.

Mr. Cantrell testified that petitioner did not report a work related injury on July 27, 2010. In fact, he testified that Petitioner continued to work his normal employment job from July 27, 2010 through October 10, 2010. At no time during this period of time did Petitioner report a work related accident or injury to Mr. Cantrell. Over that same time Petitioner never told Mr. Cantrell that he could not perform his job as a locomotive technician due to pain or problems involving his right shoulder. Mr. Cantrell specifically denied that he had any conversation with Petitioner during the first week of August, 2010 about a work related injury to him.

Mr. Cantrell testified that the first time that Petitioner reported a work related accident involving his right shoulder was on October 11, 2010. At that time Mr. Cantrell followed the company procedure and completed the documents for reporting a work related injury, which were introduced into evidence as Respondent's Exhibits #5 (RX #5:Employee Accident/Near Miss Evaluation Report), #11 (RX #11:Supervisor's Accident Investigation Report), and #12 (RX #12:Supervisor's Incident Investigation Report).

Mr. Cantrell testified that Petitioner completed and signed RX #5, the Employee Accident Report. This was the first notice of Petitioner's claimed injury. On this Mr. Cantrell noted that Petitioner reported that injured his right shoulder on August 29, 2010.

Once Petitioner reported the accident, the procedure then called for the supervisor to complete a Supervisor's Accident Investigation Report (RX #11). This was completed by David Lewis. The supervisor's report was completed and signed by Mr. Lewis on October 11, 2010. Mr. Lewis testified that this was the first date on which Petitioner reported an accident to his right shoulder and that Petitioner had noted that the date of accident was August 29, 2010.

Mr. Cantrell testified that the company procedure required that after the Supervisor's Accident Investigation Report (RX #11) was completed then the Supervisor and Operations Manager to had to complete a Supervisor's Incident Investigation Report (RX #12). This document was also completed by Mr. Lewis, based upon the information provided by Petitioner. Thereafter, the document was reviewed by Mr. Lewis and Mr. Cantrell.

David Lewis

Mr. Lewis was called to testify by Respondent. He testified that on July 27, 2010 he was employed by Respondent as a team leader. In this position he was familiar with the rules regarding reporting a work related injury in effect at the respondent on this date. According to Mr. Lewis, the rule required all work related injuries to be immediately reported to the team leader or supervisor. Once an employee reported a work related injury it was incumbent upon the team leader or the Supervisor to complete an Employee Accident Report, Supervisor's Accident Report, and Supervisor's Incident Report completed.

On July 27, 2010 Mr. Lewis was Petitioner's team leader. As the team leader he would have been one of the individuals to whom Petitioner could have reported a work related accident. Mr. Lewis testified that Petitioner did not report a work related accident to him on July 27, 2010.

Mr. Lewis testified that from July 27, 2010 through October 10, 2010 he worked with Petitioner. During that time Petitioner performed all of the normal job duties of a locomotive technician. At no time during the period from July 27 through October 10, 2010 did Petitioner report a work related injury to Mr. Lewis.

On October 11, 20101 Petitioner did report a work related injury. At that time Mr. Lewis had Petitioner complete the Employee Accident Report (RX #5). In addition, Mr. Lewis completed a Supervisor's Accident Report (RX #11) and the Supervisor's Incident Report (RX #12). Mr. Lewis testified that all of the information contained on the documents he completed was provided to him directly by Petitioner.

Christian Jostlein

On July 27, 2010 Mr. Jostlein was employed with Respondent as the safety manager/director. In this position he was familiar with the rules for reporting work related injuries. The rule required all employees to immediately report a work related injury to their supervisor. Once a work related accident was reported, it was incumbent upon the team leader and supervisor to have the employee complete the Employee Accident Report and for the supervisor and operations manager to complete a Supervisor's Accident Report and a Supervisor's Incident Report.

MacNeal Memorial Hospital (PX #1)

Petitioner had plain x-rays of his right shoulder on August 6, 2010, ordered by Dr. Robert Kash. There were no acute findings. Petitioner returned on September 30, 2010 for an MR arthrogram of the right shoulder, ordered by Dr. Michael Hejna. There were degenerative changes in the humeral head and the acromioclavicular joint. History and radiological findings noted a history of previous rotator cuff surgery. The

impression was Type II SLAP tear of the glenoid labrum without biceps tendon involvement.

Petitioner was seen in the Emergency Department on April 4, 2012 with complaints of left shoulder pain. Petitioners gave a history then of an injury when lifting a heavy object 4 days before. Examination revealed full range of motion of both upper extremities. Petitioner was diagnosed with left shoulder and back strain with directions to follow up with Dr. Hejna. Petitioner had a left shoulder MR arthrogram on April 16, 2012. He was diagnosed with left shoulder strain with directions to follow up with Dr. Hejna.

Robert Kash, M.D. (PX #4 & RX #6)

Petitioner's records with Dr. Kash begin in 2005. Petitioner was diagnosed with a cerebral vascular accident in 2005. Petitioner had a fall from a ladder in 2006 and a right knee sprain in 2009. In general petitioner consulted Dr. Kash for management of his hypertension and hyperlipidemia: October 16, 2009 and January 22, 2010

On July 29, 2010 Petitioner consulted Dr. Kash with complaints of right shoulder pain. Petitioner gave a history of shoulder pain for about one year after an injury. He was requesting an x-ray. No mention of a work-related accident was documented. Petitioner returned on August 20, 2010, complaining of persistent right shoulder pain. He reported that he had been holding onto an object and was jumping off when his shoulder pain began "last month." Again, there was no documentation of Petitioner reporting that his complaints were related to an injury at work.

Petitioner continued with Dr. Kash for management of his hypertension and hyperlipidemia: December 17, 2010; April 29, July 29, and December 2, 2011; March 16, April 4, and July 17, 2012. There was no documentation at those consultations that Petitioner complained of right shoulder pain or of a work-related injury in July 2010.

Dr. Kash's records contains Dr. Michael Hejna's October 6, 2010 chart note. On that date Dr. Hejna recorded Petitioner's history of injuring his right shoulder two years before. Dr. Hejna also recorded Petitioner's report of injuring his shoulder when climbing down from a locomotive when he fell, putting traction on his shoulder with his whole body weight. Dr. Hejna suspected a SLAP lesion. He ordered an MR arthrogram.

Dr. Kash's chart also contains the radiology report of the MR arthrogram on September 30, 2010, see PX #1.

Orthopedic Associates of Riverside/Michael J. Hejna, M.D. (PX #3 & RX #7)

Petitioner registered for care on September 3, 2010. There is no clinical note from that date. Petitioner was seen on October 6; see Dr. Kash's records above. Petitioner returned to Dr. Hejna on October 14, 2010 for follow-up for the MR arthrogram. Petitioner reported his normal activity pain a 1-2/10 but 8/10 with heavy

lifting on the job. Dr. Hejna opined that Petitioner could benefit from a SLAP repair. This would require 8 to 12 weeks off work.

There is an Activity Status Report dated October 12, 2010, noting Petitioner was able to return to work that day. The radiology reports from August 6, 2010 and September 30, 2010, see PX #1, are also included.

There are no clinical notes documenting Petitioner reporting that he was injured at work on July 27, 2010.

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 failed to prove that he sustained an accidental injury that arose out of and in the course of his employment by Respondent. This finding is primarily based on Petitioner's lack of credibility.

There are no medical records admitted in evidence documenting that Petitioner reported that he was injured at work on July 27, 2010. In fact, Petitioner filled out an Employee Accident/Near Miss Evaluation Report where he reported the injury occurred on August 29, 2010. Moreover, Petitioner reported to his physicians, Drs. Kash and Hejna, that his right shoulder problems began, alternatively one year before or two years before.

Petitioner was not credible when he testified that he reported his injury to Mr. Cantrell, his supervisor, during the week of August 4, 2010. Petitioner testified that he was well aware to work rules which required him to immediately report a work injury. The violation of that work rule aside, Mr. Cantrell was more credible when he testified that Petitioner first reported his claimed injury on October 11, 2010.

In addition, Petitioner continually throughout his testimony refreshed his memory from records he said he made contemporaneously with events due to "not having the best memory". Further, Petitioner did not present evidence which illustrated a coherent and understandable account of the origin or origins of his claimed right shoulder injury. The arbitrator takes note of the objective radiological evidence of prior right shoulder rotator cuff repair. Petitioner testified that he had not injured his right shoulder within the 10 years before 2010. In addition to the obvious contradictory histories given to his physicians, Petitioner's withholding of the entire medical or injury history of his right shoulder detracts from his credibility.

E: Was timely notice of the accident given to Respondent?

The Arbitrator finds that Petitioner failed to prove that he gave timely notice of his claimed injury to Respondent in accord with the requirements of §6(c) of the Act.

The Arbitrator has previously found that Petitioner was not a credible witness. The Arbitrator is particularly influenced by the two different dates of injured reported by Petitioner. The Arbitrator previously found the testimony of Kevin Cantrell was credible when he testified that Petitioner first gave notice of his claimed July 27, 2010 injury on October 11, 2010

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 claimed condition of ill-being is causally related to the accident.

As stated above, the Arbitrator did not find Petitioner to be a credible witness. Petitioner testified that he injured his right shoulder on July 27, 2010. On October 11, 2010 he reported that his injury occurred on August 29, 2010. He told Dr. Kash on July 29, 2010 that his shoulder had been painful for a year. He told Dr. Hejna on October 6, 2010 that he had injured his shoulder two years before.

Too many contradictions make for a witness who is not credible.

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

The Arbitrator has previously found that Petitioner failed to prove that he was injured in an accident arising out of and in the coursed of his employment, and that he failed to prove that he gave timely notice of the claimed accident to his employer, and that he failed to prove that his claimed condition of ill-being was causally related to the claimed accident. Therefore, this issue is moot.

Steven J. Fruth, Arbitrator — February 29, 2016 Date

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Mudd,

Petitioner,

vs. NO: 16 WC 27175

Grimm Express Delivery,

18IWCC0272

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, 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 30, 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.

18IWCC0272

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 $30,100.00. 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: MAY 2 - 2018
TJT:yl
o 3/6/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

MUDD, CHARLES
Employee/Petitioner

Case# **16WC027175**

16WC017489

GRIMM EXPRESS DELIVERY
Employer/Respondent

18IWCC0272

On 5/30/2017, 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:

5354 STEPHEN P KELLY
ATTORNEY AT LAW LLC
2710 N KNOXVILLE AVE
PEORIA, IL 61604

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT F DELANEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

18IWCC0272

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Charles Mudd
Employee/Petitioner

v.

Grimm Express Delivery
Employer/Respondent

Case # 16 WC 27175

Consolidated cases: 16 WC 17489

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on April 17, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, February 1, 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 $40,039.85; the average weekly wage was $775.19.

On the date of accident, Petitioner was 52 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $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 as identified in Petitioner's Exhibits 3 and 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the treatment recommended by Dr. Gibbons and Dr. Lewis.

Respondent shall pay Petitioner temporary total disability benefits of $516.79 per week for 58 weeks commencing March 7, 2016, through April 17, 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

William R. Gallagher, Arbitrator
ICArbDec19(b)

May 26, 2017
Date

MAY 30 2017

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 16 WC 17489, the Application alleged that in August, 2015 (no specific date of accident was stated), Petitioner was "Stepping out back of truck, fell and hit pallet" and sustained injuries to the right knee and right hip (Petitioner's Exhibit 1). In case number 16 WC 27175, the Application alleged Petitioner sustained "Repetitive Trauma" to the right knee and right hip, which manifested itself on February 1, 2016 (Petitioner's Exhibit 1).

These cases were previously consolidated and were heard in a 19(b) proceeding in which Petitioner sought orders for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. In regard to the accident of August, 2015, there was an issue as the date it occurred. At trial, Petitioner testified it occurred on August 1, 2015, but various medical reports/records stated that the date of accident was August 20, 2015. However, Respondent stipulated that Petitioner sustained the accident in August, 2015, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1). In regard to the repetitive trauma alleged to have manifested itself on February 1, 2016, Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 2).

On both stipulation sheets, Petitioner claimed entitlement to temporary total disability benefits for two periods of time, October 16, 2015, through November 28, 2015, a period of six and one-sevenths weeks; and March 7, 2016, through April 17, 2017, a period of 58 weeks. Petitioner and Respondent stipulated that Respondent paid Petitioner $5,540.52 representing payment of the six and one-sevenths weeks temporary total disability benefits which also included an advance payment of permanent partial disability (Arbitrator's Exhibits 1 and 2).

Petitioner started working for Respondent in November, 2014, as a truck driver/delivery person. Petitioner's job duties required him to lift and load various packages into the truck. The packages would weigh up to 150 pounds. Petitioner would then drive the truck to Respondent's customers and deliver the packages. Petitioner estimated he made approximately 90 to 130 deliveries every day. When Petitioner made the deliveries, he would have to climb in/out of the truck, lift the packages and then make the delivery. While delivering the packages, Petitioner would also, when necessary, climb up/down stairs.

Petitioner testified that on August 1, 2015, while he was in the process of getting out of the truck, he misstepped which caused him to put all of his weight on his right side and fall. At that time, Petitioner experienced pain in his right knee, but he continued to work. Petitioner reported the accident to Joe Grimm, but he did not seek any medical treatment.

Petitioner stated that the right knee got progressively worse and that Joe Grimm later directed him to go to Illinois Work Injury Resource Center. Petitioner was initially seen there on October 16, 2015, by Dr. Daniel Stopka. Dr. Stopka examined Petitioner and opined he had sustained a right knee sprain/strain. Dr. Stopka prescribed a knee brace, imposed some restrictions and ordered an MRI scan (Petitioner's Exhibit 4).

The report of the MRI was not tendered into evidence; however, when Petitioner was again seen at Illinois Work Injury Resource Center on October 23, and October 30, 2015, it was noted that the MRI revealed a torn medial meniscus and degenerative changes. An orthopedic evaluation was recommended (Petitioner's Exhibit 4).

Petitioner was seen by Dr. Michael Gibbons, an orthopedic surgeon, on November 5, 2015. At that time, Petitioner informed Dr. Gibbons that he had hurt his right knee while getting out of a truck on August 20, 2015. Dr. Gibbons examined Petitioner and reviewed the MRI. He noted the MRI revealed an acute complex tear of the medial meniscus, chondromalacia of the patella, trochlea and tibial plateau as well as osteoarthritis. He recommended conservative treatment which involved the use of a knee brace and medications (Petitioner's Exhibit 3). Petitioner was subsequently seen at Illinois Work Injury Resource Center by a Physician Assistant, Chelsea Hart in November, 2015. Petitioner received conservative treatment for his right knee condition and was authorized to be off work. When seen there on December 28, 2015, the examination of the knee was normal and Petitioner was authorized to return to work without restrictions (Petitioner's Exhibit 4).

Petitioner testified he returned to work for Respondent in a light duty capacity on November 28, 2015, and continued to work light duty until early January, 2016. At that time, Petitioner stated he returned to work to his regular job.

Petitioner testified that sometime after he returned to work for Respondent in a full duty capacity, his right knee symptoms started getting progressively worse. Petitioner also stated he started having right hip symptoms as well. Petitioner testified he again spoke to Joe Grimm and informed him that he was having both right knee and hip symptoms. Grimm then sent Petitioner back to Illinois Work Injury Resource Center.

On January 4, 2016, Petitioner was seen at Illinois Work Injury Resource Center by another Physician Assistant, Jeff Buckingham, who opined Petitioner could work without restrictions and was at MMI. However, PA Buckingham referred Petitioner to Dr. Dru Hauter, a physician associated with Illinois Work Injury Resource Center (Petitioner's Exhibit 4).

Dr. Hauter saw Petitioner the following day, January 5, 2016, and opined Petitioner had a right knee medial meniscus tear that was resolving. He opined Petitioner could work without restrictions, was at MMI and had a zero percent (0%) whole person impairment (Petitioner's Exhibit 4).

On March 7, 2016, Petitioner was again saying at Illinois Work Injury Resource Center by PA Buckingham. At that time, Petitioner stated his right knee symptoms had worsened and that he also had right hip pain. Examination of the right knee revealed effusion, crepitus and a decreased range of motion. The assessment was a right knee medial meniscus tear - acute exacerbation. In regard to the right hip pain, the note stated "...may be bursitis, most likely due to compensating for pain." Petitioner was authorized to work sedentary duty only and to return to Dr. Gibbons (Petitioner's Exhibit 4).

Dr. Gibbons evaluated Petitioner on March 14, 2016. At that time, Petitioner advised that his right knee pain previously resolved, but had returned approximately six weeks ago without new injury. Petitioner had complaints of both medial and lateral knee pain. Examination revealed some crepitus and pain on flexion and extension. Dr. Gibbons opined that the right knee pain was due to an arthritis flare-up. He recommended cortisone injections, medications and continued monitoring. He administered an injection to Petitioner's right knee at that time (Petitioner's Exhibit 3).

Petitioner was again seen by a Physician Assistant, Matthew Carr, at Illinois Work Injury Resource Center on March 17, and March 21, 2016, for right knee and right hip pain. Again, it was noted that the right hip pain was most likely due to compensation for the knee (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was seen by Dr. Hauter on May 31, 2016, for the purpose of determining if Petitioner could return to work. On examination of the right knee, Dr. Hauter noted marked tenderness and a decreased range of motion. He opined Petitioner had degenerative joint disease and that it was not safe for him to return to work as a driver. He opined Petitioner could perform sedentary duty only with a 10 pound lifting restriction but even then only occasionally. He further opined that Petitioner should not engage in any commercial driving (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Michael Lewis, an orthopedic surgeon, on July 13, 2016. In connection with his examination of Petitioner, Dr. Lewis reviewed medical records provided to him by Respondent. In regard to Petitioner's right knee, Dr. Lewis opined that Petitioner had a medial meniscus tear and degenerative arthritis. He opined that the medial meniscus tear was not causally related to the accident of August 20, 2015, because of the lack of symptoms on the medial side of the knee. He also opined that the degenerative arthritis pre-existed the accident, but that the accident did cause a temporary exacerbation of same (Respondent's Exhibit 1; Deposition Exhibit 2).

In regard to Petitioner's right hip condition, Dr. Lewis opined Petitioner had trochanteric bursitis. He opined that this was not related to either the accident of August 20, 2015, or the increased favoring of the right knee. While he opined Petitioner was at MMI for anything related to the accident of August 20, 2015, he stated Petitioner was not at MMI for his non-work right knee and right hip conditions. In regard to the right knee, Dr. Lewis recommended a program of home exercises and, for the right hip, a possible cortisone injection. He opined Petitioner could work, but with no excessive bending or stair climbing and no lifting more than 40 pounds for one month. He specifically stated that the restrictions were not because of the work-related injury (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Gibbons was deposed on August 15, 2016, and his deposition testimony was received into evidence at trial. In regard to his treatment and diagnosis of Petitioner's conditions, Dr. Gibbons' testimony was consistent with his medical records. In regard to the etiology of Petitioner's right knee condition, Dr. Gibbons testified that the findings he noted in the MRI and his examination could have been aggravated by the August, 2015 accident (Petitioner's Exhibit 2; pp 17-20).

In regard to Petitioner's right hip condition, Dr. Gibbons noted that this was a new complaint made by Petitioner in March, 2016. As to causality, Dr. Gibbons agreed that Petitioner's work activities and altered gait could have caused the right hip symptoms. He further stated Petitioner was not at MMI (Petitioner's Exhibit 2; pp 23-27).

Dr. Lewis was deposed on October 24, 2016, and his deposition testimony was received into evidence at trial. Dr. Lewis' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to Petitioner's right hip condition, he opined that this was trochanteric bursitis which was caused by everyday activities of life. He opined Petitioner did have work restrictions; however, he did not attribute these to Petitioner's accident (Respondent's Exhibit 1; pp 15, 25-26).

At trial, Petitioner testified he still has aching and popping in the right knee as well as pain and limited mobility of the right hip. Petitioner stated he has not been able to work since March, 2016, because of his right knee and right hip symptoms. He wants to return to Dr. Gibbons for further medical treatment.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent that manifested itself on February 1, 2016, and that his current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner previously sustained a compensable injury to his right knee in August, 2015, for which he received medical treatment and payment of temporary total disability benefits.

In connection with that earlier injury, an MRI scan was performed which revealed a torn medial meniscus and chondromalacia of the right knee. Dr. Gibbons opined that these conditions could have been aggravated by the August, 2015, accident.

While Petitioner experienced a temporary resolution of his right knee symptoms, they reoccurred after Petitioner returned to work at full duty for Respondent in early January, 2016.

Upon returning to work for Respondent at full duty, Petitioner began to experience both right knee and right hip pain, which he reported to Respondent.

When seen at Illinois Work Injury Resource Center in March, 2016, it was noted in the medical record that Petitioner's right hip pain was most likely due to his favoring his right leg.

Petitioner's treating orthopedic surgeon, Dr. Gibbons, opined that Petitioner's work activities could have aggravated both the right knee and right hip conditions.

Respondent's Section 12 examiner, Dr. Lewis, opined that Petitioner's right knee condition was pre-existing and not work-related and Petitioner's right hip condition was trochanteric bursitis related to everyday activities of life.

The Arbitrator found Petitioner's description of his work activities and right knee and hip symptoms to be credible.

The Arbitrator found the opinion of Dr. Gibbons, in regard to causality, to be more persuasive than that of Dr. Lewis.

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

The Arbitrator concludes that Petitioner gave notice to Respondent within the time required by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified he informed Joe Grimm of his right knee and hip problems shortly after he returned to work at full duty in January, 2016. That testimony was unrebutted.

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 Exhibits 3 and 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the medical treatment recommended by Dr. Gibbons and Dr. Lewis.

In support of this conclusion the Arbitrator notes the following:

Both Dr. Gibbons and Dr. Lewis have recommended further medical treatment for Petitioner.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 58 weeks commencing March 7, 2016, through April 17, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been unable to work at his regular job since March 7, 2016.

When seen by Dr. Hauter on May 31, 2016, Dr. Hauter opined Petitioner could not return to work as a driver and could do only sedentary work.

Respondent's Section 12 examiner, Dr. Lewis, also imposed work restrictions of no excessive bending or stair climbing and no lifting more than 40 pounds.

All of the preceding work restrictions were incompatible with Petitioner's job requirements.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Slapinski,
Petitioner,
vs.

NO: 14WC 27929

Wells Fargo,
Respondent.

18IWCC0273

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 20, 2017, is hereby affirmed and adopted.

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

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

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

DATED: MAY 4 – 2018
o050118
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SLAPINSKI, JASON
Employee/Petitioner

Case# **14WC027929**

WELLS FARGO
Employer/Respondent

18IWCC0273

On 6/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% 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:

4129 WOLFE LAW PC
KENNETH B WOLFE JR
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

2965 KEEFE CAMPBELL BIERY & ASSOC
ARIK HETUE
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
ARBITRATION DECISION

JASON SLAPINSKI
Employee/Petitioner

v.

WELLS FARGO
Employer/Respondent

Case # 14 WC 27929

Consolidated cases: NA

18IWCC0273

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **May 10, 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 **May 16, 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 **$41,678.00**; the average weekly wage was **$801.50**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$31,983.47** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$31,983.47**.

Respondent is entitled to a credit of **$116.90** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$480.90**/week for **200** weeks, because the injuries sustained caused the 40% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$534.33**/week for **76** weeks, commencing **May 17, 2014 through November 12, 2014; November 18, 2014 through July 19, 2015; and July 24, 2015** through **November 11, 2015**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$31,983.47** for TTD already paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$330 less fee schedule reductions** to **Northwestern for the initial Dr. Cybulski consultation on February 6, 2015**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$116.90** 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.

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

06-19-17
Date

ICArbDec p. 2

JUN 20 2017

STATE OF ILLINOIS)
)
COUNTY OF COOK)

18IWCC0273

Illinois Workers' Compensation Commission

Jason Slapinski	)	
Petitioner,	)	
	)	
v.	)	**Arbitrator Kurt Carlson**
	)	
Wells Fargo,	)	**IWCC #14 WC 27929**
Respondent.	)	

ATTACHMENT TO PROPOSED FINDINGS

Findings of Fact:

Petitioner, Jason Slapinski, is a 45-year-old bank loan consultant who worked for Wells Fargo for roughly two years between July 2013 and June 2015. TR 7

The parties stipulated a work related accident occurred on May 16, 2014. The parties further stipulated notice was uncontested, Petitioner's earnings in the year preceding the injury were $41,678 with a corresponding average weekly wage of $801.50, and to Petitioner's age, marital status, number of dependents. See Arb. Ex 1.

Petitioner testified to a pre-existing 2 level cervical fusion which resulted from an accident in 1988. TR 8-9 Petitioner testified over the past 5-10 years, arthritis on both sides of the fusion had progressively gotten worse, and that it was also worse with cold weather. TR 9

Petitioner testified on May 16, 2014, in the course and scope of his work, he was lifting and carrying an office printer estimated to weigh 50 pounds when he felt a sudden onset of pain in his neck. TR 8 Petitioner also testified to his medical treatment history, consistent with the summary noted under medical evidence.

Petitioner testified his current symptoms were an inability to perform daily tasks like taking out the garbage or moving groceries, shooting pains down the spine, pain through the shoulder into the triceps muscle, dead reflexes in both arms, pain to the forearm, inner and outer wrists, pinky, ring and middle fingers, tremors in the fingers, and even lumbar and sciatica which he thought were all related to the cervical injury. TR 35-36

Petitioner testified he suffers from photophobia, and that this condition was not present prior to the work accident. TR 17 Petitioner noted this appeared within days of the original May 2014 accident. TR 18 Petitioner testified he also suffered dizziness, and he did not recall this symptom prior to the work accident. TR 18-19

Petitioner testified to tinnitus and blurred vision starting after the injury, both of which he treated with Dr. Shepard. TR 23 Petitioner testified he can read, however it is just a matter of time before he experiences blurred vision or headaches if he reads. TR 38

Petitioner testified he successfully weaned off narcotics roughly one to one and a half years prior to trial, which would be sometime between December 2015 and May 2016. TR 47 Petitioner testified he currently takes only Cyclobenzaprine and Aleve for pain. TR 34

Petitioner testified the work he did as a loan officer was light duty in nature. TR 42

Petitioner testified he attempted to return to work twice following his injury, the first time on November 13, 2014 where he alleged he re-injured his neck while plugging in a computer cord. TR 16

The next time he attempted to return to work was on July 20-23, 2015. TR 29-31 During this timeframe, Petitioner testified he appeared wearing the soft collar as well as polarized lenses, he would lean up against the side of his cubicle, and without permission (TR 43) he would occasionally lay down in the conference room. *Id.* He further testified he would go out to his vehicle every 30-45 minutes and lay down on a heated seat for 15-20 minutes. TR 31

Petitioner testified he has not attempted to return to work since July 23, 2015. TR 34 He testified he has a valid driver's license. TR 49 He further testified to his experience of 15 years in the loan writing profession, and noted it would be simple to renew his license if he returned to this line of work. TR 49-50

Medical Evidence

Petitioner testified he presented to the St. Alexius Hospital ER on the date of accident. TR 9 ER Records from St. Alexius Medical Center dated May 16, 2014, where a cervical spine CT scan showed post-op changes in the anterior fusion at C5-6, plate and screw implants, degenerative changes in the cervical spine with neural foraminal stenosis, which appeared greater on the right side at C3-4. PX 1 Petitioner was recommended a soft cervical collar, Robaxin, Medrol Dose Pak, Norco, and was taken off work until cleared by neurosurgeon, Dr. Kanu Panchal. *Id.*

On May 19, 2014, Petitioner presented to Dr. Thomas James at Alexian Brothers Medical Group complaining of neck pain with radiating numbness and tingling to the left forearm and 3-5th fingers. PX 1 Dr. James noted the CT scan in the ER showed no acute changes and Petitioner was diagnosed with a cervical strain with radiculopathy. *Id.* Petitioner was referred to a neurosurgeon and work restrictions were not discussed. *Id.*

On May 20, 2014, Petitioner presented to Dr. Kanu Panchal at Alexian Brothers Medical Center severe neck pain and stiffness, numbness radiating the left arm and last three fingers, dizziness, and occipital headaches. PX 2 Petitioner stated he had a successful cervical fusion in 1988 at Northwestern Hospital, and he did not have any pain in his neck since his surgery up until May 16, 2014, when he was "*lifting a printer over a desk and suddenly felt sharp pain in the neck*".

Id. Dr. Panchal noted the CT scan take in the ER showed degenerative changes at C6-7 and C7-T1, his impression was severe cervical radiculopathy status post anterior cervical fusion at C5-6. *Id.* Petitioner was recommended a cervical spine MRI, prescribed Norco, and was to remain off work for two weeks. *Id.*

On May 27, 2014, Petitioner presented to Dr. Panchal advising he had the MRI scheduled at Bright Light Radiology, but he could not tolerate the procedure, so he rescheduled the MRI at St. Alexius Medical Center. PX 2 Petitioner stated he also could not tolerate Norco, so he destroyed it. *Id.* Petitioner was prescribed Tylenol #3 and recommended to continue wearing the cervical collar. *Id.*

On May 30, 2014, Petitioner presented to St. Alexius Medical Center for a cervical spine MRI. PX 1, PX 2 The impressions were metal artifact due to anterior fusion at C4-5 and C5-6, which obscured the anterior portion of the spinal canal; narrowing of the right C3-4 neural foramen in the bilateral C4-5 neural foramen due to bony hypertrophy; and no evidence of central spinal canal stenosis. *Id.*

On June 3, 2014, Petitioner presented to Dr. Panchal complaining of neck pain and stiffness radiating to both arms. PX 2 Dr. Panchal noted the cervical spine MRI was very poor quality due to the metal artifact from the prior fusion. *Id.* The diagnosis was cervical radiculopathy and Petitioner was recommended physical therapy, an EMG study of bilateral upper extremities, was to continue use of the cervical collar, and remain off work for a month. *Id.*

Petitioner attended physical therapy in June 2014, and demonstrated minimal improvement. PX 3

On June 24, 2014, Petitioner presented to Dr. Panchal complaining of severe neck pain and stiffness radiating to the left arm. Px 2 Petitioner stated physical therapy was worsening his symptoms, and he was recommended to discontinue therapy. *Id.* Physical exam showed significant restricted neck range of motion, mild muscle spasms and weak handgrips bilaterally. *Id.* Petitioner was recommended a cervical epidural steroid injection, prescribed Ultram, and kept off work until the end of July 2014. *Id.*

On July 22, 2014, Petitioner presented to Northwest Neurology for an EMG/NCV study. PX 2 The study was normal and there was no evidence of median or ulnar mono-neuropathy for either upper extremity, and no evidence of cervical radiculopathy or brachial plexus injury for either upper extremity. *Id.*

On August 5, 2014, Petitioner presented to Dr. Panchal complaining of neck pain and stiffness radiating to the left arm. PX 2 Dr. Panchal noted the EMG was normal, and his physical exam showed minimal restricted movement, no muscle spasms, tenderness or upper extremity weakness. *Id.* Dr. Panchal's impression was cervical radiculitis status post cervical fusion and he did not believe Petitioner required a myelography or surgery, but did recommend physical therapy. Petitioner was kept off work until September 9, 2014. *Id.*

By August 11, 2014, Petitioner completed 8 sessions of physical therapy for cervical radiculopathy at Midwest Physical Therapy; Petitioner was noted to demonstrate poor tolerance of exercises and complained of ongoing pain. PX 3

On August 18, 2014, Petitioner requested cessation of physical therapy for cervical radiculopathy at Midwest Physical Therapy due to dizziness with repeated changes in position. PX 2, PX 3 Petitioner was noted to continue poorly tolerate exercises and complained of increased pain. *Id.*

On October 8, 2014, Petitioner presented to St. Alexius Medical Center for a cervical myelogram and CT scan. PX 1, PX 2 The impressions were post-operative changes at anterior fusion C5-6 and degenerative changes; moderate central slightly left paracentral C6-7 disc protrusion with slight narrowing of the spinal canal without significant spinal stenosis; and mild bilateral C6-7 neural foraminal stenosis. *Id.*

Petitioner presented to St. Alexius ER on November 14, 2014 with complaints of pain to the neck stemming from an October 8, 2014 injury, with an aggravation on November 13, 2014 at work due to bending over to plug in a computer and upon rising he felt "pulling" in the neck. PX 1 The records indicate this occurred on Petitioner's first day back after being off work for the cervical surgery. *Id.* Petitioner requested a refill of Oxycodone, and a referral to a pain clinic for a possible injection, all of which were provided. *Id.* Petitioner also requested an off work slip for two weeks,, and one is in the record, however the off work note is highly illegible and the Arbitrator cannot conclude this validly took Petitioner off work. *Id.*

On November 18, 2014, Petitioner presented to Dr. Panchal complaining of neck pain and stiffness radiating to bilateral arm. PX 2 Dr. Panchal agreed with Dr. Goldberg that cervical epidural steroid injections were warranted and referred Petitioner to Dr. Mehta. *Id.* Petitioner was also referred for a neurological exam with Dr. Farbman due to dizziness. *Id.* Petitioner was taken off work for one month, and while no date was noted on the off work slip, this would run through December 18, 2014. *Id.*

Petitioner presented to Dr. Sunavoi Dasgupta of Premier Pain Specialists on December 2, 2014, for a cervical epidural steroid injection under IV sedation. PX 2

On February 6, 2015, Petitioner presented to Dr. George Cybulski at Northwestern for a cervical radiculopathy consultation. PX 4 After the exam and his review of past medical records, Dr. Cybulski's diagnosis was bilateral C7 radiculopathy due to a work accident on May 16, 2014. *Id.* Petitioner was recommended an anterior C6-7 discectomy and fusion with possibility of removing the prior plate implant at C5-6, since conservative treatments have failed. *Id.* Petitioner was recommended off work through surgery. *Id.*

Petitioner presented to Northwestern on February 19, 2015 for pre-operative testing; he was cleared for surgery. PX 6 Of note, Petitioner listed migraines and blurry vision with unknown cause as a symptom. *Id.*

On February 26, 2015, Petitioner presented to Dr. Cybulski and Dr. Gircesan at Northwestern Memorial Hospital for surgery. PX 4, PX 6 Dr. Cybulski first provided an anterior cervical

discectomy at C6-7, decompression of the spinal canal and foramen with removal of the disk. *Id.* An anterior interbody fusion with low-profile PEEK spacer with end plate screws was then performed by Dr. Gireesan. *Id.* Petitioner was discharged without issue on February 27, 2015 with a cervical collar and prescribed Norco and Flexeril. *Id.*

On March 10, 2015, Petitioner presented to Diane M. Yonan, CNP for a status post two week post-operative exam of the cervical spine. PX 4 Petitioner complained of left arm pain and numbness, and also complained of "unrelated migraines and blurry vision he had pre-op". *Id.* Petitioner was recommended to follow up with Dr. Alan G. Shepard for a neurology exam for these issues. *Id.*

On March 26, 2015, Petitioner presented to Dr. Alan G. Shepard for a neurology exam due to headaches, neck pain, sound and light sensitivity, tinnitus and difficulty focusing on text when reading. PX 6 Petitioner stated he has had light and sound sensitivity and tinnitus since the work accident in May 2014, but he was able to drive. *Id.* Dr. Shepard noted abnormal facial sensation on his neurological exam, which suggested a brain tissue. *Id.* Petitioner was referred to Dr. Nicholas J. Volpe for a neuro-ophthalmology exam and recommended a brain MRI. Id.

On March 26, 2015, X-rays of the cervical spine showed stable spinal construct and normal coronal balance. PX 6

On May 15, 2015, Petitioner presented to Dr. Cybulski complaining of ongoing cervical radiculopathy symptoms. PX 4 Dr. Cybulski noted this was not uncommon after longstanding radiculopathy, and recommended continued use of Oxycodone and Gabapentin. *Id.* Dr. Cybulski indicated Petitioner was to remain off work for at least 24 months. *Id.*

On June 8, 2015, Petitioner presented to Dr. Cybulski complaining of ongoing cervical radiculopathy and pain bilaterally in the arms. PX 4 Petitioner was recommended a TENS unit; work restrictions were not addressed. *Id.*

On July 14, 2015, Petitioner presented to Northwestern for a brain MRI due to headaches. PX 6 The impression was an unremarkable MRI of the brain with no abnormalities found. *Id.*

On July 14, 2015, Petitioner presented to Dr. Maria E. Reese at the Shirley Ryan Abilitylab on referral from Dr. Cybulski. PX 7 Petitioner was there for a new-patient pain management evaluation due to neck and arm pain, anxiety, depression, and sleeping problems. *Id.* Petitioner also complained of headaches, numbness, tingling and weakness. *Id.* Petitioner's current medications were noted as Percocet, Flexeril and Gabapentin. *Id.* The impressions were cervical radiculitis, photophobia, headaches and tinnitus; Petitioner was recommended to wean off the cervical collar and recommended to undergo comprehensive pain management at RIC. *Id.* Dr. Reese noted she did not prescribe Percocet and advised Petitioner he would have to have the medication filled by his surgeon. *Id.*

On July 20, 2015, Petitioner presented to Dr. Cybulski complaining of chronic neck and arm pain. PX 4 Dr. Cybulski noted the X-rays showed the surgical implants were in good position. *Id.* Dr. Cybulski opined Petitioner had chronic pain syndrome in the neck and arms and referred

Petitioner to RIC for pain management. *Id.* Petitioner was to remain off work through his next re-evaluation on October 26, 2015, and was not released to drive at that time. *Id.*

Petitioner testified an evaluation took place on August 5, 2015 however no records were submitted into evidence for that date of treatment. TR 31

On July 27, 2015, Petitioner presented to Dr. Nicholas J. Volpe for an ophthalmology exam due to visual discomfort and photophobia. RX 4 The exam was essentially normal except for farsightedness. *Id.* Dr. Volpe noted "*it is difficult to discern what aspects of the symptoms may be related to the underlying cervical injury; however, it is possible that meningeal irritation occurring from the neck injury could be contributing*". *Id.* Petitioner was recommended OTC reading glasses. *Id.*

An off work certification signed by Dr. Cybulski dated October 7, 2015 indicated Petitioner was off work and would be re-evaluated on November 16, 2015. PX 4

On October 30, 2015, Petitioner presented to Dr. Benjamin Marshall at Rehabilitation Institute of Chicago (RIC) for a pain management evaluation for neck and bilateral arm pain. PX 7 Petitioner was noted to still be using the cervical collar even though no physician had recommended continued use. *Id.* Current medications were Norco, Cyclobenzaprine, Gabapentin, Atrovastatin and Ibuprofen. *Id.* Past psychiatry history included use of Prozac in the 1990s, but he stopped since his doctor told him to stop taking them due to distrust with drug companies and ingredients used in the medications. *Id.* Petitioner stated his mother is bipolar and his sister had recurrent suicide attempts. *Id.* The doctor's impressions were: axial cervico-thoracic myofacial pain; bilateral upper extremity pain, sleep disorder; mood disorder with depression and anxiety; headache with report of photophobia; and chronic opioid dependence. *Id.* Dr. Marshall noted some of the symptoms were radicular and some were myofascial. *Id.* He also noted markedly restricted cervical range of motion, which was out of proportion to prior fusions. *Id.* Petitioner's case was discussed with Dr. James Atchison, the attending physician, and Dr. Song, a pain psychologist. *Id.* Petitioner was recommended the RIC chronic pain program and was to start increasing Gabapentin and decreasing opioids after starting program. *Id.*

On November 12, 2015, Petitioner presented to Dr. Nicholas Volpe for an ophthalmology exam for light sensitivity, blurred vision and difficulty focusing. PX 8 Dr. Volpe noted the exam showed no specific findings to correlate the complaints of blurred vision or focusing difficulty, and there was "*no identifiable exam finding to suggest a cause for photophobia. I have seen unexplained photophobia after closed head injury before although not with neck injury*". RX 4

On January 18, 2016, Dr. Cybulski produced a letter addressed to "To Whom It May Concern" wherein Dr. Cybulski noted Petitioner suffered a work-related neck injury resulting in a cervical fusion. PX 4 Though the fusion had no complications, Petitioner complained of persistent pain and pain management had been recommended. *Id.* Dr. Cybulski stated Petitioner is "completely disabled from work with persistent pain in his neck and his arms as well with tingling. His strength remains intact". *Id.*

Expert Testimony

On August 18, 2014, Petitioner presented to Dr. Edward Goldberg for a Section 12 independent medical examination at Respondent's behest. RX 1 Petitioner denied any major pain or discomfort from his 1988 cervical fusion, until the lifting incident at work in May 2014, and presented with complaints of bilateral arm and neck pain, upper extremity numbness, headaches, blurred vision and dizziness. *Id.* Dr. Goldberg could not come to a definitive diagnosis since the prior cervical implant was blocking the MRI, and his working diagnosis was cervical radiculopathy. *Id.* He opined all treatment rendered was reasonable and necessary, and opined Petitioner should have a myelogram and CT scan and remain off work.

On October 13, 2014, Dr. Goldberg produced an addendum IME report. *Id.* Dr. Goldberg noted the CT myelogram showed a well-healed C5-6 fusion with instrumentation intact, and C6-7 degenerative disc disease with osteophyte complex causing central and bilateral foraminal stenosis. The diagnoses were aggravation of asymptomatic cervical stenosis due to a disc osteophyte at C6-7 below a healed fusion at C5-6, and causation was supported to the work injury.
Petitioner was recommended 1-2 cervical epidural steroid injections, and if there was no relief from the injections, then a C6-7 anterior cervical discectomy and fusion would be recommended. Dr. Goldberg reviewed Petitioner's job description and noted the job could require him to lift up to 25 lbs. Petitioner was released to work with restrictions of no lifting over 10 lbs. *Id.*

On June 15, 2015, Petitioner presented to Dr. Edward Goldberg for a Section 12 independent medical examination at Respondent's behest. RX 1 Petitioner complained of visual disturbances and light sensitivity, along with neck and arm pain. *Id.* Dr. Goldberg noted he was not able to review any of the post-operative X-rays to show whether or not the instrumentation were intact, and he opined if post-operative X-rays showed healing and instrumentation as intact, then physical therapy was immediately recommended. *Id.* He further opined Petitioner could be released to sedentary work, but was first recommended to wean down the pain medications prior to driving. Id.

On June 26, 2015, Dr. Goldberg produced an addendum IME report. RX 1 The March 26 and June 8, 2015 cervical spine X-rays were reviewed and showed bone grafting and instrumentation was intact. *Id.* Petitioner was recommended a FCE to determine return to work capabilities and released to sedentary duty in the meantime. *Id.*

On July 1, 2015, Dr. Goldberg produced an addendum IME report where he declined to provide an opinion on causation for visual disturbances since it was not his specialty. *Id.*

On October 26, 2016 the evidence deposition of Dr. George Cybulski was taken by agreement of the parties. PX 5 Dr. Cybulski testified accurately regarding the history of injury and the course of treatment. *Id.* at p. 4-9 Dr. Cybulski ultimately testified Petitioner had chronic cervical radiculopathy with chronic pain syndrome as of the last time he saw Petitioner. *Id.* at 9-11. Dr. Cybulski testified Petitioner was at MMI and had permanent restrictions including a 10 pound restriction, 30 minute sitting restriction, and 15 minute standing restriction. *Id.* at 11-12 Dr.

Cybulski testified Petitioner could work consistent with these restrictions if an employer could accommodate them. *Id.* at 13

Under cross examination, Dr. Cybulski testified Petitioner "was at MMI when [he] saw him last." *Id.* at 18 While he could not comment on whether Petitioner was at MMI prior to January 16, 2016, Dr. Cybulski reiterated MMI would have been by that date at least. *Id.* Dr. Cybluski testified Petitioner's complaints of photophobia and tinnitus were not related to his work accident. TR 26-27 Dr. Cybulski testified he never discussed driving restrictions with Petitioner, nor did he ever give Petitioner a driving restriction. TR 28

On March 30, 2017 Sharon Babat MS, CRC for CompAlliance Managed Care produced a vocational assessment wherein she opined Petitioner could obtain full time employment based upon the restrictions outlined by Dr. Cybulski in his deposition. RX 2

On April 11, 2017 Ms. Babat produced a labor market survey confirming numerous positions for which Petitioner was qualified and which were consistent with the restrictions noted by Dr. Cybulski. RX 3 Numerous positions in the sales, loan advisement, and loan consultant fields earning more than his pre-DOL wages were noted. Id.

Medical Bills

Petitioner submitted a number of medical bills as PX 9. In addition to PX 9, a summary listing of the bills contained therein was marked as Arb. Ex. 2. Respondent submitted a payment ledger as RX 5 listing all payments made to date on the file.

Conclusions of Law:

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

The Arbitrator adopts and incorporates the above findings of fact as appropriate.

The Arbitrator finds Petitioner's current condition is in part causally related to the work injury. Specifically, the conditions of ill-being consisting of a herniated disc with a subsequent anterior discectomy and fusion in the context of a pre-existing fusion at the adjacent level, with chronic radicular pain following resolution of care also being causally related.

Petitioner testified to a variety of other conditions, including tinnitus, photophobia, blurry vision, headaches, pain into the low back, tremors in the hands, and an overall inability to perform his daily activities. All of these conditions are denied as unrelated to the work accident.

The Arbitrator notes Dr. Volpe could not provide a definitive opinion relating the photophobia or blurred vision to the neck injury, and in fact he specifically noted the exam in November 2015 showed no specific findings to correlate the complaints of blurred vision or focusing difficulty, and there was no identifiable exam finding to suggest a cause for photophobia.

The Arbitrator notes Dr. Cybulski specifically testified he had no way to opine the tinnitus nor the visual symptoms were related to the work injury.

The remainder of the complaints about which Petitioner testified are either non-existent in the medical records submitted as evidence, or for the existing issues such as blurred vision, no doctor has opined there was a causal link to the accident.

Item J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator adopts and incorporates the above findings of fact as appropriate. The Arbitrator finds all care submitted into evidence by Petitioner, through October 30, 2015, necessary, reasonable and causally related to the work accident. After this date are two records which were submitted as evidence – a follow up appointment to Dr. Volpe for unrelated vision issues, and what purports to be a record from Dr. Cybulski, but which is in fact a narrative report he authored summarizing his opinions.

Petitioner submitted a number of medical bills as PX 9. In addition to PX 9, a summary listing of the bills contained therein was marked as Arbitrator's Exhibit 2. Respondent submitted a payment ledger as RX 5 listing all payments made to date on the file.

The specific bills in question will be addressed individually:

- A Northwestern bill in the amount of $219 for the November 12, 2015 visit to Dr. Nicholas Volpe – the Arbitrator notes Dr. Volpe had already examined Petitioner prior to this date and he was unable to relate his condition to the work accident. As such, this bill for follow up care for an unrelated condition is denied.

- Northwestern Medicine bill in the amount of $464 for the date of service February 19, 2015, which includes a consultation and various lab charges – The Arbitrator notes medical records were submitted into evidence which confirm this as the date of the pre-operative testing. Respondent's PX 5 shows multiple payments for bills with this date of service, totaling over $700 in payments following fee schedule reduction, all payments posting between March 19, 2015 and June 4, 2015 – as the statement date for this set of bills is listed as March 23, 2015, the Arbitrator declines to award them as they appear paid.

- Northwestern Medicine bill in the amount of $187 for the date of service February 26-27, 2015, which includes x-rays and various lab charges – The Arbitrator notes this was the date of Petitioner's surgery. Respondent's PX 5 shows 33 payments for bills with this date of service, all payments posting between March 26, 2015 and June 4, 2015 – as the statement date for this set of bills is listed as March 23, 2015, the Arbitrator declines to award them as they appear paid.

- Northwestern bill in the amount of $330 for the date of service from February 6, 2015 – The Arbitrator notes this was the initial consultation with Dr. Cybulski, and there is no corresponding payment in RX 5 for this visit. As such the Arbitrator awards this bill per the fee schedule.

- Petitioner submitted a summary printout from Walgreens identifying multiple entries for prescriptions being filled. No corresponding coded bills were submitted with these printouts, nor was any testimony presented regarding whether these were unpaid bill balances, balances Petitioner paid out of pocket, or payments made by a group provider. The Arbitrator is unable to ascertain from the evidence submitted if these are in fact unpaid balances, and as such these bills are denied.

- The final bills submitted were from Premier Pain Specialists for an ESI noted on the ledger as administered on December 10, 2014 with a handwritten modification to the charge reducing it from $1,650 to $566.60, and for an indeterminate charge of $10.36 for Hydrochloride on December 2, 2014. The Arbitrator notes the only medical records from Premier submitted into evidence are for an injection provided on December 2, 2014, and RX 5 lists payments for both of these charges reflecting a December 2, 2014 date of service. As such, these bills are denied.

In total, the Arbitrator denies all medical bills submitted except for the February 6, 2015 bill from Northwestern for the initial consultation with Dr. Cybulski, which is awarded per the fee schedule. Petitioner is to be held harmless for any outstanding medical records related (causally connected) to this claim.

Item K. What temporary benefits are in dispute?

The Arbitrator adopts and incorporates the above findings of fact as appropriate.

Pursuant to the stipulations entered into in Arbitrator's Exhibit 1, Petitioner asserted TTD entitlement from May 17, 2014 through November 12, 2014, from November 14, 2014 through July 20, 2015, and from July 24, 2015 through November 11, 2015. Respondent acknowledges and stipulated to TTD for the periods from May 20, 2014 through November 12, 2014 and again from November 18, 2014 through July 20, 2015. The Arbitrator notes Petitioner testified he returned to work on July 20, 2015 for a full day, so regardless of stipulations, that day will not be awarded.

Based on those stipulations, the following time periods are in dispute: May 17-20, 2014, November 14-18, 2014, and July 24-November 11, 2015.

For the period of May 17-20, 2014, this is the initial three days of lost time – the Arbitrator notes there is mention of light duty in the medical records from the ER, but there is also another record of Petitioner being off work until evaluated by a specialist. As such, the Arbitrator finds Petitioner was entitled to TTD for this time period.

For the period of November 14-18, 2014, the Arbitrator notes Petitioner testified he returned to work on November 13 where he alleged an aggravation. Records indicate Petitioner presented to St. Alexius ER on November 14, 2014 where he requested an off work slip for two weeks. The Arbitrator notes there is a highly illegible off work slip in the file with no corresponding mention of off work status in the ER records from that time, and due to these issues, the Arbitrator cannot conclude this validly took Petitioner off work. As such, TTD for this period is denied.

For the period of July 24, 2015 through November 11, 2015, the Arbitrator notes Petitioner testified he returned to work from July 20-23, 2015, after being advised of available sedentary work by his employer, consistent with the IME opinions of Dr. Goldberg that Petitioner could work sedentary duty pending an FCE. Petitioner testified he elected to cease coming to work on July 24, 2015 at which time he returned to Dr. Cybulski.

Contained in the records of Dr. Cybulski is a valid treating record taking Petitioner off work during this time frame, specifically from July 20, 2015 through October 26, 2015. Further, during this timeframe, Dr. Cybulski recommended Petitioner pursue pain management at RIC, and Petitioner did in fact pursue said treatment at RIC. As such the Arbitrator awards this time frame.

In total, the Arbitrator awards TTD for the following time periods: May 17, 2014 through November 12, 2014; November 18, 2014 through July 19, 2015; and July 24, 2015 through November 11, 2015.

The parties further stipulated Respondent had paid a total of $31,983.47 in TTD benefits, and Respondent is due a credit for said payments.

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

The Arbitrator adopts and incorporates the above findings of fact and conclusions of law as appropriate.

The Arbitrator finds Petitioner sustained a cervical herniation, which required an anterior cervical discectomy and fusion. The Arbitrator finds Dr. Cybulski's testimony persuasive in this matter – specifically that Petitioner had chronic radicular pain after surgery, however Dr. Cybulski further testified this would not prevent him from returning to work. While Petitioner has ongoing complaints of a wide variety of symptoms, the Arbitrator has found only the chronic radicular complaints to be related to the original work injury.

With respect to the nature and extent of the injury, Dr. Cybulski outlined what appear to be a reasonable set of restrictions for Petitioner to return to an office setting work environment – alternating sitting and standing, use of a standing desk as needed, and a 10 pound lifting restriction.

Dr. Cybulski testified Petitioner was at MMI and could pursue work within those restrictions as of January 2016. Petitioner testified Respondent accommodated all his requested modifications during his return to work in July 2015, and further testified he has never after that time period attempted to return to work for Wells Fargo, nor for any other employer.

Petitioner submitted no evidence of job searches, did not allege entitlement to any TTD or maintenance after November 11, 2015 on Arbitrator's Exhibit 1, and but for the narrative of Dr. Cybulski contained in his records, which he contradicted in his deposition, Petitioner has submitted no evidence of ongoing medical lost time after the date of November 16, 2015.

Respondent produced a vocational assessment and labor market survey outlining numerous positions in the same and similar fields as Petitioner's prior employment. Earnings in this labor market survey range from $15 per hour to over $90 per hour. The vast majority of the positions identified by Ms. Babat have starting salaries above Petitioner's earnings while working for Respondent.

The Arbitrator notes Petitioner is a college educated man with a valid driver's license who by his own testimony has not taken narcotic medication since at least May 2016. Further, Petitioner testified it would be a simple process for him to get re-licensed to continue loan consultancy work.

In *Westin Hotel v. Industrial Commission*, 372 Ill.App.3d 527, 545, the Appellate Court noted that "... most recent cases making an odd lot determination on the basis that there is no stable job

market for a person of the claimant's age, skills, training, and work history have required evidence, from a rehabilitation services provider or a vocational counselor."

In a recent decision, the Commission ruled that in order to prove entitlement to permanent total disability benefits for life pursuant to § 8(f) of the Act, a claimant must prove such a claim either (a) by a preponderance of the medical evidence, (b) by showing a diligent but unsuccessful job search, or (c) by demonstrating that because of his age, training, education, experience and condition no jobs are available to a person in like circumstances. *Patricia Burrola, Petitioner*, 08 IL. W.C. 16484 (Ill. Indus. Com'n Apr. 4, 2017)

In this case, the Arbitrator finds that the unrebutted Labor Market Survey conducted by Respondent's vocational rehabilitation counselor, in conjunction with the testimony of Dr. Cybulski and the opinions of Dr. Goldberg, are persuasive. As there is no evidence to rebut Respondent's labor market survey, nor any evidence of a protracted job search, the Arbitrator cannot conclude Petitioner is permanently and totally disabled under an "odd lot" theory.

The Arbitrator finds Petitioner sustained a compensable cervical herniation which required a discectomy and fusion surgery, and that he is capable of work within the restrictions outlined by Dr. Cybulski.

Further, while there is no question Petitioner has significant permanent restrictions, there is no evidence to suggest Petitioner cannot return to a similar line of work as his pre-injury position. Respondent's unrebutted vocational reports, the opinions of Dr. Goldberg, and Dr. Cybulski's specific testimony this would be possible with minor workspace modifications, all confirm a loss of trade award is inappropriate here.

Based on all of the forgoing, the Arbitrator awards Petitioner $480.90 per week for 200 weeks as he sustained permanent partial disability to the extent of 40% loss of use of the person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yolanda Vasquez,

Petitioner,

vs. NO: 14WC 35441

Walgreens,

18IWCC0274

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 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 4, 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.

18IWCC0274

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,300.00. 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.

MAY 4 - 2018

DATED:
o050118
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

VASQUEZ, YOLANDA
Employee/Petitioner

Case# **14WC035441**

14WC035442

WALGREENS
Employer/Respondent

18IWCC0274

On 5/4/2017, 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 0.97% 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:

5709 STROW LAW LLC
THOMAS STROW
628 COLUMBUS ST SUITE 501
OTTAWA, IL 61350

2389 GILDEA & COGHLAN
JEREMY J MAZZA
901 W BURLINGTON SUITE 500
WESTERN SPRINGS, IL 60558

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

YOLANDA VASQUEZ
Employee/Petitioner

v.

WALGREENS
Employer/Respondent

Case # 14 WC 35441

Consolidated cases: 14 WC 35442

18IWCC0274

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada** Arbitrator of the Commission, in the city of **Geneva and Wheaton**, on **2/10/17 and 4/26/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 27, 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 **$50,041.16**; the average weekly wage was **$962.33**.

On the date of accident, Petitioner was **35** 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 for any and all TTD and medical expenses it has already paid on this claim.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,133.00 to Central DuPage Hospital (for 2/17/12 services), $2,445.25 to Central DuPage Hospital (for 2/23/12 services), $1,545.00 to Dr. Yang (for 2/23/12 services), $4,027.00 to Central DuPage Hospital (for 3/9/12 services), and $1,030.00 to Dr. Yang (for 3/9/12 services), as provided in Sections 8(a) and 8.2 of the Act.

As the Arbitrator has found that Petitioner failed to prove that her current condition of ill-being is causally related to the January 27, 2011 work accident with Walgreens, Petitioner's claim 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.

Signature of Arbitrator

5/3/17
Date

MAY 4 - 2017

18IWCC0274

FINDINGS OF FACT

This claim involves a Petitioner who has filed an Application for Adjustment of Claim for two dates of accident with both cases consolidated. This decision is on the claim with an alleged accident date of January 27, 2011. Petitioner's other alleged accident occurred on November 2, 2013 (14 WC 35442) – which will be addressed in a separate decision. At trial the issues in dispute for the present claim were: 1) causation, 2) medical expenses and 3) prospective medical care.

Petitioner testified that she began working for Respondent in November 1998. On January 27, 2011, she was completing her duties as an executive assistant manager, which included unloading a warehouse truck and operating a two-wheeled dolly stacked with totes, when she experienced a pull in her back. Her duties varied, and included hiring, training, ordering items, cleaning, unloading, and dealing with insurance.

On the date of the accident, Petitioner presented to St. Alexius Medical Center. Her complaints included low back pain and limited ROM. She reported to the emergency provider a "history of pinched nerve in [her] back." She received Norco and Flexeril, and directions to follow up with her family physician. (PX 27).

Petitioner testified that she sought treatment with her "family doctor." She then pursued chiropractic treatment with Dr. Mark Wilk on February 8, 2011. A "Workers Compensation Questionnaire" included in Dr. Wilk's records referenced a prior "injury" to "this area" in 2006 which required her to miss time from work. Additionally, the form stated that Petitioner had a prior Workers Compensation claim. (PX 3, p. 5) A later "Patient Medical History and Intake Questionnaire" from Accelerated Rehabilitation dated May 6, 2011 reflected that Petitioner had experienced low back symptoms previously in 2006, for which she underwent treatment with a medical provider in Warrenville, IL. (PX 5, p. 7).

Petitioner testified that she had not received treatment or therapy to her back prior to the January 27, 2011 accident at Walgreens, and that she had never had a workers' compensation injury before January 2011.

Petitioner underwent treatment with Dr. Wilk from February 8, 2011 through February 11, 2011. (PX 3). She testified that her family doctor then referred her to an orthopedic specialist. On April 6, 2011, Petitioner presented to Dr. O'Connor of Castle Orthopedics. She reported left-sided low back pain, with associated pain, numbness, and tingling radiating to her buttock, lateral thigh, and lateral calf. Dr. O'Connor diagnosed Petitioner with lumbar radiculitis, probably due to a herniated disc. He recommended she obtain an MRI, and removed her from work for two (2) weeks. Petitioner also received a script for Norco. (PX 4, p. 26).

On April 22, 2011, Petitioner underwent an MRI of the lumbar spine, which revealed mild spondylosis at the L4-5 and L5-S1 levels with mildly bulging discs and mild facet hypertrophy. There did not appear to be any significant impingement upon the thecal sac or nerve roots at any lumbar level. (PX 9, p. 1208-1209).

Petitioner returned to Dr. O'Connor on April 27, 2011 reporting pain radiating from the left side of the low back to the left posterior thigh but not below the knee. She noted occasional tingling in the feet.

Dr. O'Connor noted that the MRI showed degenerative changes at L4-5 and L5-S1 with bulging discs and facet hypertrophy. Dr. O'Connor further noted that there was no obvious evidence for radiculitis, and recommended she begin a course of therapy and remain off work. (PX 4, p. 24-25).

Petitioner commenced physical therapy at Accelerated Rehabilitation on May 6, 2011. (PX 5, p.45-46). She returned to Dr. O'Connor on May 18, 2011, reporting 75% improvement with therapy. Dr. O'Connor provided Petitioner with light duty work restrictions to include no lifting greater than 10 pounds, no bending, kneeling, or squatting. He recommended she continue physical therapy. (PX 4, p. 23).

She next returned to Dr. O'Connor on June 17, 2011 and reported an increase in symptoms when "trying to lift a shelf" the previous day. Her symptoms were now localized at the right side of the low back. Dr. O'Connor diagnosed a lumbosacral strain and provided her with work restrictions to include no lifting greater than five (5) pounds. (PX 4, p. 20). On June 28, 2011, Petitioner saw Dr. O'Connor reporting ongoing low back pain, now radiating towards the right lower extremity into the thigh. She also reported numbness and tingling to the posterior thigh and lateral knee region. Straight leg raise was positive on the right side for pain radiating to the posterior thigh. Dr. O'Connor stated that Petitioner's symptoms seemed to "wax and wane" and recommended she see Dr. McGivney to evaluate for a possible disc herniation. In the interim, she could continue working with restrictions of no lifting greater than five (5) pounds, and no bending, squatting, kneeling, or stooping. (PX 4, p. 19).

Dr. McGivney saw Petitioner on July 13, 2011, who reported periodic pain into her left buttock to her left anterolateral thigh and down to the anterior aspect of the knee. Dr. McGivney stated that Petitioner's prior MRI showed an annular tear at L5-S1, mild degenerative bulge, and well-maintained disc height at L4-5. Dr. McGivney could not explain her L3 radicular pain pattern. Her buttock and back pain was likely consistent with the annular tear. He did not believe her bulging disc at L4-5 was symptomatic. Dr. McGivney recommended a repeat MRI of the lumbar spine, likely to be followed by epidural steroid injections. (PX 4, p. 18, RX 2). On July 22, 2011, Petitioner underwent an updated MRI of the lumbar spine which revealed degenerative disc disease and facet arthrosis at L4-5, resulting in mild bilateral foraminal narrowing. There was also a shallow left medial foraminal disc protrusion at L5-S1, but no significant foraminal stenosis. (PX 8, p. 1210). Dr. McGivney saw Petitioner on August 9, 2011and noted that her MRI did not show any interval change, and that there was "no surgical option for her." Petitioner requested pain medication, which Dr. McGivney denied to her. He suggested that Petitioner pursue a trial of epidural steroid injections. She could continue working on a light duty basis, with no lifting greater than 10 pounds, and no bending or stooping. Dr. McGivney also suggested that Petitioner might also consider a work conditioning program to "settle her leg pain down." (PX 4, p. 14-15, RX 2).

The August 20, 2011 Discharge Note from Accelerated stated that Petitioner had not attended any therapy visits since June 3, 2011. The therapist reported that Petitioner "would have benefitted from additional therapy." (PX 5, p. 57-58).

Petitioner's Medical Bills Exhibit states that Petitioner received treatment at Central DuPage Hospital on October 2, 2011, incurring a charge of $1,139.50 for this visit. The medical records do not include any description of any treatment received on this date (see PX 33, p. 7-14).

18IWCC0274

On December 1, 2011, Petitioner attended a Section 12 examination with Dr. Alexander Ghanayem of Loyola University Medical Center. Petitioner denied any prior low back injuries. Dr. Ghanayem reviewed Petitioner's MRI scan and interpreted disc degeneration at L4-5 with a subtle protrusion at L5-S1 that had some asymmetry to it, displacing one nerve root posteriorly on the left side. Dr. Ghanayem diagnosed Petitioner with an aggravation of her lumbar disc disease, resulting from the work injury. He recommended Petitioner pursue lumbar epidural injections. Dr. Ghanayem stated that Petitioner was without neurologic deficits, and that her degree of nerve root encroachment was not that big. As a result, he did "not think surgery would be appropriate." The degenerative changes at L4-5 appeared to be pre-existing. Petitioner could continue to work at her regular job and would be at MMI after a "couple of injections." (RX 3).

Petitioner presented to Central DuPage Hospital on February 17, 2012 with complaints of lower back pain after "lifting heavy things" at work the prior day. Her symptoms radiated to her left thigh, and were aggravated by bending and twisting. After receiving pain medications, Petitioner reported improvement in symptoms. (PX 6, p. 6-11).

On February 23, 2012, Petitioner presented to Dr. Edward Yang for a pain management consult. She reported low back pain, with symptoms radiating into the right thigh. Dr. Yang's assessment included low back pain, facet arthropathy, degenerative disc disease, L4-5/L5-S1 disc bulges, mild right radiculopathy, and myofascial pain/muscle spasm. Dr. Yang recommended injections, with therapy for core muscle strengthening, and continued light duty until Petitioner could be re-evaluated. On this date, Dr. Yang performed a lumbar epidural steroid injection under fluoroscopic guidance at L4-5. (PX 7, p. 8-12). Petitioner received a second epidural steroid injection at L4-5 on March 9, 2012, and a third epidural steroid injection at L4-5 on March 30, 2012. (PX 7, p. 17-18).

On May 19, 2012, Petitioner re-started therapy with Accelerated Rehabilitation. On that date, she reported left-sided low back pain. Injections had helped to relieve "pressure" in her back. The therapist stated that Petitioner presented with lumbopelvic instability and would benefit from therapy to address dysfunction, ROM, and strength. (PX 5, p. 59-60.). Petitioner continued regular therapy with Accelerated, and commenced a course of "dry needling" which provided her with good relief of her symptoms. (See PX 5, p. 81-82). On August 20, 2012, Petitioner was discharged from therapy. She reported that since beginning the dry needling, she had not experienced any pain. Petitioner stated that she felt fatigued at the end of her work day, and with certain activities, but overall she felt "a lot better." Her pain complaints at the time of this visit were 0/10. (PX 5, p. 86-87).

The medical records show that Petitioner presented to Central DuPage Hospital on May 19, 2013 with complaints of low back pain radiating down her left leg. Petitioner felt that her pain was "out of control." She was discharged with oral steroids, pain medications, and a muscle relaxer. (PX 6, p. 18-23).

Petitioner's Medical Bills Exhibit shows that Petitioner incurred charges from a visit with Dr. Larsen of Northwestern Family Medicine on July 1, 2013 totaling $229.00. The treating medical records indicate that Petitioner followed up with this provider on this date for a toe nail infection, and referenced a prior history of anxiety with recent worsening of symptoms due to pressures of pharmacy exams. (PX 22, p. 5-8).

18IWCC0274

Petitioner testified that her condition never returned to her pre-work injury state. She returned to work for Respondent without any restrictions and testified that she noticed pain in her back and her leg prior to the second work injury on November 2, 2013. Petitioner stated that she took Ibuprofen and exercised at home during this time. Petitioner testified that on November 2, 2013 she was unloading a truck when she felt something "snap" in her back while grabbing a box. Following this incident, Petitioner began a lengthy course of medical treatment which included back surgery, and will be discussed in greater detail in the decision for the Petitioner's companion case under 14 WC 35442.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her January 27, 2011 accident. This finding is supported by both the Petitioner's testimony and the medical evidence. While it is undisputed that the Petitioner did sustain an injury to her back following the January 27, 2011 incident, the Petitioner's condition had stabilized to the point where her medical records show Petitioner reported her pain level was 0/10 as of August 20, 2012 when she was discharged from therapy. The Arbitrator finds persuasive the opinions of Dr. Ghanayem, who indicated that the Petitioner had sustained an aggravation of her lumbar disc disease that should be treated with injections, and that Petitioner would reach MMI after the injections. Petitioner testified and the medical evidence shows that she did undergo the injections along with conservative care, and then returned to regular work thereafter. Having reached maximum medical improvement and returning to work without restrictions prior to her second accident on November 2, 2013, the Arbitrator concludes that the Petitioner's current condition of ill-being is not causally related to her work accident with Respondent on January 27, 2011.

2. With regard to the issue of medical expenses the Arbitrator finds that the following medical expenses are reasonable, related and necessary in the treatment of the Petitioner's back condition, and accordingly awards these expenses to Petitioner subject to the fee schedule:

- $1,133.00 (Per PX 1) to Central DuPage Hospital (for services on February 17, 2012) relating to a visit for back pain radiating to the left thigh;
- $2,445.25 (Per PX 1) to Central DuPage Hospital (for services on February 23, 2012);
- $1,545.00 (Per PX 1) to Dr. Yang (for services on February 23, 2012) relating to pain management treatment;
- $4,027.00 (Per PX 1) to Central DuPage Hospital (for services on March 9, 2012); and
- $1,030.00 (Per PX 1) to Dr. Yang (for services on March 9, 2012) relating to pain management treatment.

The Arbitrator states that Respondent paid bills owing to Mark Wilk Chiropractic Clinic per the medical fee schedule, and that any remaining balances represent "balance billing," which is not permitted by the Act. The Petitioner failed to present any medical records or documentation supporting the October 2, 2011 balances owing to Central DuPage Hospital ($1,139.50 per PX 1). As the Arbitrator cannot determine the diagnosis or treatment received on that date, Respondent is not liable for these balances. The Arbitrator finds that Respondent is not liable for charges from Winfield Radiology Group dated April 13, 2012 (totaling $229.00 per PX 1) as these charges relate to a CT scan of the head that Petitioner received during a trip to Central DuPage Hospital on that date. The Arbitrator also finds that Respondent is not liable for charges claimed by Dr. Larsen ($229.00 per PX 1) for date of service July 1, 2013 as the

18IWCC0274

medical records show that Petitioner complained of a toe nail infection and anxiety relating to the pressure of pharmacy exams during this visit. (PX 22, p. 5-8).

The Arbitrator finds that Respondent paid any and all remaining reasonable and/or necessary medical charges relating to the January 27, 2011 work accident at Walgreens.

3. Regarding the issue of prospective medical care, the Arbitrator finds that the Petitioner is not entitled to prospective medical treatment. In support of this finding, the Arbitrator relies on the medical evidence showing that Petitioner's condition had stabilized and reached a state of permanency prior to the November 2013 work accident. The Arbitrator finds persuasive the opinions of Dr. Ghanayem who found that Petitioner achieved MMI as of the date of his March 5, 2015 examination. Accordingly, the Petitioner's request for prospective medical treatment is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yolanda Vasquez,

Petitioner,

vs. NO: 14WC 35442

Walgreens,

Respondent.

18IWCC0275

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 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 4, 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: MAY 4 - 2018
o050118
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

VASQUEZ, YOLANDA
Employee/Petitioner

Case# **14WC035442**

14WC035441

WALGREENS
Employer/Respondent

18IWCC0275

On 5/4/2017, 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 0.97% 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:

5709 STROW LAW LLC
TOMMY STROW
628 COLUMBUS ST SUITE 501
OTTAWA, IL 61350

2389 GILDEA COGHLAN & REGAN LTD
JEREMY J MAZZA
901 W BURLINGTON AVE SUITE 500
WESTERN SPRINGS, IL 60558

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

YOLANDA VASQUEZ
Employee/Petitioner

v.

WALGREENS
Employer/Respondent

Case # **14** WC **35442**

Consolidated cases: **14 WC 35441**

18IWCC0275

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva and Wheaton**, on **2/10/17 and 4/26/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 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* 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 **$53,959.36**; the average weekly wage was **$1,037.68**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of **$3,756.41** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,000.00** for an advance, for a total credit of **$8,756.41**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the providers indicated in the attached findings as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $691.79/week for 1 2/7 weeks, commencing October 12, 2014 through October 20, 2014, as provided in Section 8(b) of the Act.

As the Arbitrator has found that Petitioner failed to prove that her current condition of ill-being is causally related to the November 3, 2011 work accident, Petitioner's claim 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.

Signature of Arbitrator

5/3/17
Date

MAY 4 – 2017

18IWCC0275

FINDINGS OF FACT

This claim involves a Petitioner who has filed an Application for Adjustment of Claim for two dates of accident with both cases consolidated. This decision is on the claim with an alleged accident date of November 2, 2013. Petitioner's other alleged accident occurred on January 27, 2011 (14 WC 35441) – which will be addressed in a separate decision. The issues in dispute for the present claim are: 1) causation, 2) medical expenses; 3) TTD and 4) prospective medical care.

Petitioner began working for Respondent in 1998. On November 2, 2013, Petitioner worked for Respondent as an Assistant Manager, whose varied duties included hiring, training employees, ordering products, cleaning, and unloading trucks. Petitioner had returned to work following a prior back injury on January 27, 2011 – which is the subject of a separate decision under 14 WC 35441. Although Petitioner returned to work without medical restrictions following her January 27, 2011 accident, Petitioner testified that she continued to have lower back pain.

On November 2, 2013, Petitioner was unloading a warehouse truck when she grabbed a box and felt a snap in her back. She could not move and was subsequently taken to the Central DuPage hospital by her husband. Petitioner testified that she was working with restrictions at the time and was told by her manager to do work that went beyond her restrictions.

At Central DuPage Hospital, Petitioner presented with complaints of left-side lower back pain shooting down her left leg. She had decreased ROM with no spasm. She received medication and was ordered to remain off work. (PX 6)

On November 27, 2013, Petitioner began her treatment at Cadence Occupational Health, where she underwent physical therapy. An MRI taken on November 27, 2013 revealed a small left-sided disc herniation at L5-S1 appearing to contact the left S1 nerve root as it exits the thecal sac, and extends into the lateral recess. There was also mild to moderate degenerative change of the disc at L4-5 with mild disc bulging and no definite neural impingement. (PX 8, p. 26-27). Petitioner received a referral to see an orthopedic specialist on December 2, 2013 (PX 31, p. 11-13).

On December 11, 2013, Petitioner presented to Dr. Jerome Kolavo of Cadence Orthopedics. She denied any significant history of ongoing low back problems prior to an injury that occurred at work on November 2, 2013. Petitioner did report a "minor low back problem" from a work injury in 2010 that resolved after six weeks of physical therapy. She also noted a diagnosis of a "bulging disc," though she had not required "any ongoing or consistent treatment for this." At the time of Dr. Kolavo's exam, Petitioner reported occasional symptoms of pain traveling into the left buttock, leg, and lateral thigh. She did report some numbness earlier in her clinical course, but stated that 70% of her current problems were in the low back. Dr. Kolavo reviewed Petitioner's MRI from November 2013 and interpreted degenerative changes most advanced at L4-5 with early degenerative changes at L5-S1. There was a small left central bulging at L5-S1 which did not compress the neural elements. Assessment was low back pain with lumbar degenerative disc disease and lumbar radiculitis. Dr. Kolavo recommended high-dose NSAIDs and aggressive physical therapy, to include long-distance walking. He felt Petitioner could return to work on a light duty basis, with no lifting greater than 10 pounds, no bending, twisting, squatting, stooping, or kneeling. (PX 8, p. 19-21, 42, RX 2).

18IWCC0275

Petitioner continued to attend therapy at DCH Aurora Physical Therapy. A Daily Note from December 31, 2013 stated that Petitioner had returned to work on December 12, 2013. She felt "a lot" better and noted that she didn't really have pain. Petitioner stated that she was "not consistent" with her home exercise program. She appeared to display increased function and decreased pain. The therapist noted that Petitioner would progress more quickly with "consistent exercise performance" and reiterated that Petitioner did not appear to be consistent with a HEP. (PX 33, p. 143-146).

Petitioner followed up with Dr. Kolavo on January 10, 2014 reporting ongoing back pain with some left buttock and thigh pain. She had been working light duty. The notes state that "physical therapy has not been approved yet by her insurance carrier." On exam, Petitioner exhibited a normal gait and good strength. She had diffuse lumbar tenderness with no spasm. Dr. Kolavo reiterated his recommendations for therapy and light duty. Petitioner requested stronger pain medication. Dr. Kolavo encouraged her to use OTC Tylenol products to supplement her prescription NSAIDs. (PX 8, p. 17-18).

On February 12, 2014, Petitioner returned to Accelerated Rehabilitation for further physical therapy. Her complaints on that date included back pain in the sacrum region, into the left buttock and mid-thigh. (PX 5, p. 125-127). An Outpatient Physical Therapy Discharge Note from DCH Aurora Physical Therapy, dated February 17, 2014, stated that Petitioner had not been seen at that facility since December 31, 2013. She had not scheduled any visits since that time, and when reached on the phone, Petitioner stated that "she is not sure what she wanted to do." The therapist noted at the time of the last visit, Petitioner "did not appear to be consistent with HEP and had returned to work." She was discharged from this facility due to her lack of attendance. (PX 33, p. 115-117).

Petitioner next returned to Dr. Kolavo on February 18, 2014. She was still having back pain but was making gradual progress. Petitioner reported taking only OTC Aleve and had backed off her prescription Naprosyn. Exam revealed tenderness at the lumbosacral junction but no spasm. Dr. Kolavo recommended she transition from light duty to full duty in the "next couple of weeks." He encouraged her to participate in more long-distance walking and use of anti-inflammatory medications. Petitioner could return to work on a full duty basis, effective March 3, 2014. (PX 8, p. 15-16, 40, RX 2).

Petitioner returned to DCH Aurora Physical Therapy, whose records indicate that she experienced decreased pain in her low back and continued to have difficulty with lifting and carrying activities (See e.g. PX 5, p. 132). During a therapy visit on February 25, 2014, Petitioner reported that she did not complete any lifting activities at work. However, she did report lifting 10 cases of water out of her trunk. (PX 5, p. 134). In a Daily Note from March 26, 2014, Petitioner reported to her therapist that she had been "very busy at work and unable to complete HEP activities." (PX 5, p. 154).

On April 3, 2014, Petitioner presented to her family physician, Dr. Larsen, with complaints of back pain. Petitioner expressed to Dr. Larsen her desire for "surgical intervention." Symptoms on that date included low back pain radiating down the left leg with numbness in the foot. Assessment was chronic lumbar radiculopathy. Dr. Larsen provided Petitioner with a neurosurgical referral to Dr. Lee. (PX 22, p. 15-18).

On May 6, 2014, Petitioner saw neurosurgeon Dr. Peter Lee on referral from Dr. Larsen. Petitioner reported "stabbing" low back pain radiating into the left leg, stopping at the knee. She also noted some tingling in the left buttock. Petitioner felt her pain had "progressively worsened" over the last month. She reported some numbness and tingling in both of her feet, and all of her toes, for the past week.

18IWCC0275

Following his exam, Dr. Lee diagnosed Petitioner with lumbar degenerative disc disease, low back pain, and left lower extremity pain. He recommended Petitioner consider further pain management options, including possible facet injections, medial branch blocks, or radiofrequency ablation. Dr. Lee felt Petitioner had evidence of degenerative disc disease at L4-5 and L5-S1, most noticeable at L4-5, where there was also evidence of facet pathology. Petitioner reported that she had seen Dr. Kolavo, who did not recommend spine surgery. Dr. Lee agreed that based upon Petitioner's age and imaging findings, he would not recommend surgery at this point. He did agree to write Petitioner a script for an updated MRI of the lumbar spine, and suggested she consider neurological evaluation for her bilateral foot numbness. (PX 2, RX 2).

In a Progress Report dated May 7, 2014, Petitioner's therapist at Accelerated stated that Petitioner's progress had been "slower than we initially expected." Petitioner had an "inconsistent attendance to physical therapy and completion of her HEP..." which could contribute to her "fair mechanics with lifting, pushing, pulling." Petitioner also noted increased pain symptoms with daily activities and work activities, hindering her progress with physical therapy. (PX 5, p. 167-169). Notes from Accelerated indicate she was last seen on May 7, 2014. (PX 5, p. 119). Dr. Kolavo recommended discharge from therapy on May 21, 2014. (PX 5, p. 120). She was formally discharged from therapy with Accelerated Rehabilitation on July 30, 2014. (PX 5, p. 173-175).

On May 23, 2014, Petitioner saw Dr. Edward Yang on referral from Dr. Lee for pain management, including possible facet injections or radiofrequency ablation. Following his exam, Dr. Yang's diagnosis was exacerbation of low back pain, with degenerative disc/facet disease, spinal stenosis, and myofascial pain/spasm. Dr. Yang performed bilateral lumbar facet joint injections at L4-5 and L5-S1 on this date and his post-operative diagnosis was lumbar facet arthritis, facet syndrome. (PX 7, p. 20-24). Dr. Yang administered a second injection on June 11, 2014 and a third injection on June 26, 2014. (PX 7). Due to her continued complaints, Dr. Yang later administered a lumbar medial branch nerve radiofrequency ablation from L4-S1 on the left side on August 8, 2014 and subsequently on the right side on August 28, 2014. (PX 7).

On May 28, 2014, Petitioner underwent an updated MRI of the lumbar spine. The scan showed mild degenerative changes in the lower lumbar spine at L4-5, L5-S1 similar to the prior study (on November 27, 2013) without significant central stenosis or foraminal narrowing. (PX 6, p. 158).

Petitioner presented to Dr. Larsen on September 26, 2014 with "ongoing back pain." Dr. Larsen's records indicate that "2 independent specialists advise that surgical intervention inappropriate at this stage." Petitioner stated that she was unable to bend or lift, and was experiencing chronic pain. She felt that "work may be at jeopardy and may need to file for disability." Dr. Larsen provided Petitioner with a referral to "Physical Medicine Rehab." (PX 22, p. 18-22).

She returned to Central DuPage Hospital on October 12, 2014 with pain across her whole lower back, worsening as of one (1) week ago. Petitioner also reported some numbness to her left thigh. She felt her back pain was exacerbated by heavy lifting of containers at work. Petitioner reported that "even though she has a note from a doctor indicating that she cannot lift heavy things, she is continuously made to lift these heavy containers which worsens her back pain." She felt that Naprosyn was not sufficient for her pain, and requested pain medication. X-rays of the lumbar spine on this date showed mild degenerative change of the L4-5 disc. Her pain was better controlled after Norco and Valium. The ER physician

18IWCC0275

suggested that Petitioner follow up with her primary or orthopedic physician for a possible updated MRI. She could remain off work for "several days." (PX 6, p. 37-44).

On October 15, 2014, Petitioner saw Dr. Corcoran, one of her family physicians. She had been off work since her trip to the ER on October 12, 2014 and did not feel ready to return to work. Petitioner was directed to continue her medications and remain off work until her evaluation with Dr. Froese on October 20, 2014. (PX 32, p. 5-10).

On October 20, 2014, Petitioner presented to Dr. Beth Froese of Cadence Orthopedics on referral by Dr. Larsen for ongoing low back pain. Petitioner stated that the conservative measures received to date had been helpful in alleviating some of her symptoms, but she continued to have pain. She was currently working at a full duty level, though she had been off work for about a week due to her pain. Following the exam and review of Petitioner's diagnostic testing, Dr. Froese diagnosed Petitioner with greater trochanteric bursitis, lumbar degenerative disc disease, myofascial pain with question of fibromyalgia. Dr. Froese provided Petitioner with a script for Lyrica for a possible component of soft tissue mediated pain contributing to her symptoms, and recommended further physical therapy. Petitioner could return to work with no lifting greater than 15 pounds for two (2) weeks, transitioning to full duty thereafter. (PX 8, p. 12-14, 39, RX 2).

In October, 2014, Petitioner had returned to work when she was approached by Walter Klepper, a chiropractor who was a customer at her store. Mr. Klepper is also a convicted felon who was involved in making a false report to a police officer. Mr. Klepper proceeded to ask Petitioner what was wrong with her and then advised her that she should not be working and that she should see him for treatment. Petitioner described Mr. Klepper as intimidating and Petitioner felt scared when Mr. Klepper told her he would take her off work. Nevertheless, Petitioner began to see Mr. Klepper for treatment.

Klepper testified via evidence deposition on January 12, 2016. Klepper failed to provide a curriculum vitae at his deposition, but testified that he is a licensed physician, who received his Doctor of Chiropractic Medicine in 1997. Klepper testified that he went into Walgreens, saw the Petitioner hobbling around, asked her what was wrong with her and discovered that she was injured at work. Petitioner began to see her after that encounter. Despite having a background in chiropractic care, Klepper testified that he did not provide chiropractic care to Petitioner. (PX 10, p.10) He described the services he provided to Petitioner as "Conservative palliative care after evaluating her condition; which entailed requesting records, consulting with other sources and physicians..." (PX. 10, p.9-10) He further explained that his role in Petitioner's treatment was "medical management," which included the coordination of her testing. During his cross-examination testimony, Mr. Klepper consistently testified that he was not aware of Petitioner's prior medical history. For example, when asked about whether the Petitioner's medical history shows a worsening of her condition, Mr. Klepper responded that the question should be directed to Dr. O'Keefe – the orthopedic specialist referred by Klepper - or Dr. Sokolowski – the orthopedic surgeon referred by Dr. O'Keefe. Klepper explained that his treatment of Petitioner also included any treatment provided by Dr. O'Keefe and Dr. Sokolowski. Klepper confirmed and the records from his deposition show that the Illinois Supreme Court found Klepper guilty of a felony conviction for falsely reporting to an officer that an offense had been committed. (PX 10 - Klepper Deposition Respondent's Exhibit 1; See People of the State of Illinois v. Walter Klepper (March, 2009)). Klepper further described the opinions of Dr. Ghanayem in this matter as "poppycock" and the efforts of Respondent in this matter as "discriminatory," citing to Dr. Louis Pasteur. Klepper also refers

18IWCC0275

to the IWCC as "inept" and describes the legal system as "crippled and unable to defend an injured worker." (PX 10 - Klepper Deposition Respondent's Exhibit)

On November 5, 2014, Petitioner presented to Dr. John O'Keefe of Marian Orthopedics on referral by Dr. Klepper. Petitioner reported receiving no significant benefit from treatment to date. She felt the practitioners who had managed her "are not hearing her high level of complaints and symptoms." Dr. O'Keefe recommended "electrical testing of her back and lumbar plexus looking for radiculopathy." On exam, Petitioner exhibited "intense spasm" at the lumbosacral junction with exquisite tenderness from L3-5. She also had exquisite tenderness in the left sciatic notch with evidence of "intense left sciatica." Dr. O'Keefe examined Petitioner's MRI report and diagnosed "traumatic discal herniation." He provided Petitioner with Norco, Relafen, Protonix, and Terocin patches, along with Utram ER. Dr. O'Keefe wrote a prescription for additional therapy with Klepper to include "McKenzie exercises" and a home exercise program. Petitioner was directed to remain off work. (PX 11, p.28-30). Petitioner continued treatment with Dr. Klepper in early November, with pain complaints consistently between 7-8/10. (See PX 9, p. 1153-1250). A Reevaluation report from November 17, 2014 stated that her injury had been "worse due to activities of daily living." Her muscle spasms had increased. She was scheduled to undergo EMG testing with Dr. Paly. (PX 9, p. 1153-1154). She returned to Dr. O'Keefe on November 19, 2014 reporting ongoing pain complaints. Petitioner was very unhappy with her circumstance and limitations. Exam revealed flattening and spasm with intense tenderness from L4-S1. Dr. O'Keefe recommended Petitioner pursue an evaluation with Dr. Hassan, a pain specialist. Petitioner remained on excused absence per Dr. O'Keefe. (PX 11, p. 12, 25).

Dr. O'Keefe testified via evidence deposition on January 21, 2016. He is an orthopedic surgeon who has a strong relationship with Dr. Klepper. Dr. O'Keefe testified that he managed Petitioner's medical prescriptions and ordered her therapy, which was performed by Dr. Klepper. Dr. O'Keefe opined that Petitioner "recovered...fully" from the 2011 injury, and that the 2013 incident was the "cause" of her condition of ill-being at the time she started treatment with him. (PX 12, p. 22-23). Dr. O'Keefe testified that he diagnosed Petitioner with a "traumatic discal herniation" based upon his interpretation of the MRI report from May 28, 2014 and his clinical exam. He felt that this traumatic discal injury was located at L4-5 and L5-S1. Dr. O'Keefe agreed that the radiologist from the May 28, 2014 report did not characterize her condition as a traumatic disc herniation. (PX 12, p. 41-44). Dr. O'Keefe admitted that his chart did not include records from Dr. Klepper detailing the treatment Petitioner received at Aarrow Healthcare from the date of Dr. O'Keefe's initial evaluation in November 2014 through the date of the surgery with Dr. Sokolowski in June 2015. As a result, Dr. O'Keefe agreed that he could not identify with any specificity the type of treatment Dr. Klepper provided to the Petitioner during this time. (PX 12, p. 50-51).

On December 17, 2014, Petitioner presented to Dr. Mark Sokolowski reporting "limited benefit" from prior treatment measures received. She felt that her symptoms were "unbearable" and that she "had been unable to continue working" as a result of her condition. Petitioner stated that she was "unwilling and incapable of tolerating her symptoms as they currently are." She wished to explore surgical options. Dr. Sokolowski examined Petitioner's MRI from May 2014 and interpreted L4-5 degenerative disc disease with adjacent Modic changes, along with an annular tear and milder degenerative changes at L5-S1. Assessment was lumbar pain with some features of lumbar radiculopathy. Dr. Sokolowski felt Petitioner had clear clinical evidence of axial back pain with "significant" degeneration of the L4-5 disc. As a result, he felt Petitioner was a candidate for lumbar fusion surgery. Dr. Sokolowski recommended provocative discography from L3-S1. (PX 16, p. 295-295).

18IWCC0275

Following the visit with Dr. Sokolowski, Petitioner continued her treatment with Aarrow Healthcare and Dr. Klepper. A Reevaluation report from December 15, 2014 stated that Petitioner did not have any significant difference in her symptoms since her last visit. A "Patient Progress Update" from this date stated that Petitioner was still reporting "a lot of lower back pain" and she felt she was "not getting any better." Her mobility had not improved, and her pain had not been reduced. (PX 9, p. 1065, 1071). Reports from subsequent visits with Dr. Klepper show continued symptoms between 7-9/10 in the lower back. (See PX 9, p. 1007-1063).

She next returned to Dr. O'Keefe on January 7, 2015 with "intense back pain." The injections she received "were not at all curative." Dr. O'Keefe noted Dr. Sokolowski's treatment recommendations and stated that he believed she was "entirely consistent, reasonable, and severely hurt." He noted that Petitioner continued to seek narcotic medications. (PX 11, p. 22).

Petitioner returned to Dr. Abdellatif on January 8, 2015 with reports of pain 7/10 radiating to the bilateral lower limbs and mid back. Dr. Abdellatif noted the recommendation for the discogram, and advised Petitioner to remain off work. (PX 14, p. 22-23). According to notes from Dr. Klepper on January 15, 2015, Dr. O'Keefe recommended that Petitioner reduce her visits with Klepper to once per week. At the time of the reevaluation on January 15, 2015, Petitioner reported pain at 8/10. (PX 9, p. 936).

On January 21, 2015, Petitioner underwent the discogram with Dr. Abdellatif. The discography revealed concordant discogenic pain at L4-5 and L5-S1. Post-discogram CT scan showed a 3-4 mm broad-based disc herniation with mildly extruded nucleus pulposus at L4-5, and 3-4 mm left paracentral disc herniation with mild left-sided spinal stenosis and narrowing the left lateral recess at L5-S1. Dr. Abdellatif also performed trigger point injections and another epidural steroid injection a L4-5 on this date. (PX 14, p. 6-7, 15-21).

Petitioner presented to Central DuPage Hospital on January 28, 2015 with complaints of right leg pain for one (1) week after a discogram. She also reported some tingling in the right leg. Petitioner expressed concern about possible DVT. She underwent Doppler studies which were negative. Petitioner received Norco and muscle relaxants. (PX 6, p.55-62).

She returned to Central DuPage Hospital on January 31, 2015 with low back pain radiating down her buttocks and into the right leg. Petitioner also noted possible fever, and concerns about an infection following the discogram. She underwent an updated MRI on this date which did not show any spinal epidural abscess or cauda equina syndrome. The findings were overall stable from the prior MRI on May 28, 2014. The notes from the visit indicate that she did not require acute hospitalization, surgical decompression, antibiotics, or infectious disease consult. (PX 6, p. 63-77).

On February 2, 2015, Petitioner presented to Dr. Sokolowski noting lumbar pain with radiation to the buttocks and lower extremities to the knee, but generally not beyond. Petitioner stated that she was "eager to proceed with surgery as she reports that her symptoms are intolerable." She rated her back pain at 8/10 and her leg/buttock pain at 8/10. Dr. Sokolowski reviewed the post discogram CT scan which showed two (2) levels of disc pathology at L4-5 and L5-S1. The more severe level was L4-5. Dr. Sokolowski requested the opportunity to review the discogram report to confirm possible surgical options. He noted that Petitioner had some co-existent features of lumbar radiculopathy, but that the "overwhelming predominance" of her symptoms was in the low back. (PX 16, p. 284-285).

18IWCC0275

Petitioner followed up with Dr. Abdellatif on February 3, 2015. She noted pain level at 8/10 on that date radiating to her bilateral lower limbs and mid back. Her ROM remained limited due to pain. Medications helped to control and relieve her pain temporarily. Dr. Abdellatif recommended Petitioner remain off work while awaiting surgical approval. (PX 14, p. 8, 10-11).

Petitioner returned to Dr. O'Keefe on February 25, 2015. She was in a surgical protocol with Dr. Sokolowski. Dr. O'Keefe renewed her prescription medications which included Norco, Tramadol, Relafen, Prilosex, Dendracin cream, and Terocin patches. He also recommended that Petitioner continue treatment with Dr. Klepper once a week. (PX 11, p. 21). During this period, Petitioner continued to treat with Dr. Klepper on a weekly basis. A note from March 2, 2015 stated that Petitioner's lifting injury had been "worse due to activities of daily living." She complained of pain at 10/10, and advised Dr. Klepper that she was unable to wash herself or perform other normal activities of daily living without undo discomfort. (PX 9, p. 768).

On March 5, 2015, Petitioner returned to Loyola University Medical Center for a second Section 12 examination with Dr. Ghanayem. Her complaints on that date included back pain at the lumbar base, with right-sided leg pain. Petitioner's pain was in the buttock, lateral thigh, and into the anterior portion of the lower leg. Exam of the lumbar spine revealed diffuse tenderness starting at T10 all the way down to the sacrum. There was tenderness to light palpation with a single finger. Petitioner reported low back pain with axial compression of the head, truncal rotation through the knees, and distraction through the shoulders. The lower extremity neurologic exam revealed no focal motor deficits. Dr. Ghanayem reviewed Petitioner's lumbar scan from May 2014 which revealed disc degeneration at L4-5 and L5-S1. The prior disc herniation had reabsorbed. There was no neurologic compression in the lumbar spine. Dr. Ghanayem also noted that Petitioner's discogram was concordant at L4-5 and L5-S1. Impression was subjective complaints of back and leg pain in the context of multiple nonorganic physical exam findings. Dr. Ghanayem felt her exam was consistent with symptom magnification. Her subjective complaints of leg pain were not substantiated by objective diagnostic testing, and her nonorganic pain behaviors were a significant cause for concern in that her symptoms were "not truly structural in nature." While she did have a positive discogram, the presence of diffuse back pain was "not consistent with two level disc disease as would be expected from the result of the discogram." Dr. Ghanayem stated that Petitioner had reached MMI and could return to work on a full duty basis. He stated that a lumbar fusion would be contraindicated based upon the illness behaviors found during the examination. (RX 4).

Petitioner also saw Dr. Sokolowski on March 5, 2015. Dr. Sokolowski noted that the discogram showed concordant pain generation at L4-5 and L5-S1. Petitioner stated that she was "unwilling and incapable of tolerating her symptoms." She was "eagerly awaiting approval for surgical management." Dr. Sokolowski recommended she proceed to lumbar fusion from L4-S1 to address her axial pain back. She might benefit from decompression at the time of surgery to address her coexistent radiculopathy. Dr. Sokolowski fitted Petitioner with a semi-rigid lumbosacral orthosis, and removed her from work pending surgical approval. (PX 16, p. 269).

She next returned to Dr. O'Keefe on March 18, 2015 stating that she had been "diligent with exercises" but that she felt she had "deteriorated since she stopped at Accelerated 5 months ago." Dr. O'Keefe stated that he wanted her to "go back to physical therapy." He felt she was "losing flexibility and power." (PX 11, p. 20). On the same date, Dr. Klepper authored a narrative report, addressed to Dr. O'Keefe, wherein he discusses his examination of Dr. Ghanayem's IME report, and his belief that Dr.

18IWCC0275

Ghanayem's opinions and impression of Petitioner's diagnostic imaging were "poppycock." (PX 9, p. 702-703).

Petitioner presented to Dr. Sokolowski on March 23, 2015. Dr. Sokolowski examined Dr. Ghanayem's report and recommended that Petitioner undergo an evaluation by an independent psychologist to determine whether Petitioner had illness behaviors which would complicate surgical management. On March 27, 2015, Petitioner underwent Functional Capacity testing at Central DuPage Physical Medicine. Petitioner received a referral from Dr. O'Keefe to undergo the testing. She reported pain at 7/10 in the low back and leg. The notes indicate a "lack of improvement with physical therapy" and suggested that Petitioner might consider "a higher level of therapy," including work conditioning or work hardening. The report states that Petitioner could return to work in a "light" strength category. Her maximum lifting capacity with 20 pounds, and her maximum carrying capacity was 10 pounds. The report also suggested that Petitioner met the strength requirements of a "Manager, Branch Store" as identified in the Dictionary of Occupational Titles. (PX 9, p.608-612).

After resuming treatment with Dr. Klepper three (3) times per week, Petitioner continued to report pain symptoms between 7-8/10 during visits and evaluations with Dr. Klepper. Dr. Klepper's notes regularly indicate that Petitioner's injury was "worse due to activities of daily living." A Reevaluation report from April 16, 2015 stated that Petitioner's objective findings were "unchanged." She felt increased pain with standing, walking, and lifting activity. (See PX p. 658-674).

Petitioner returned to Dr. O'Keefe on April 22, 2015. He recommended that Petitioner continue to see Dr. Klepper twice a week, pursuing McKenzie and core strengthening, with modalities to quiet symptoms. (PX 11, p. 18).
Petitioner presented to Dr. Larsen on May 4, 2015 after a hospitalization in April. She had been diagnosed with colitis and underwent a colonoscopy. Petitioner stated that she had been unable to tolerate pain medications or muscle relaxants. Dr. Larsen directed Petitioner to avoid NSAIDs. (PX 22, p. 26).

On May 5, 2015, Petitioner returned to Dr. Sokolowski reporting continued eagerness to proceed with surgery. She was still attempting to schedule an evaluation with a psychologist. (PX 16, p.192-193). Petitioner continued to treat with Dr. Klepper, reporting pain symptoms between 8-9/10. A note from May 7, 2015 stated that Petitioner's daily activities were severely affected when grocery shopping. (See PX 9, p. 625). Dr. Klepper authored a letter, dated May 14, 2015, suggesting that Respondent was engaging in "discriminatory efforts" to deny the Petitioner healthcare, and referencing Petitioner's Hispanic background. (PX 9, p. 594).

On May 27, 2015, Dr. Karen Hermann of Presence Behavioral Health authored a report to Dr. Sokolowski. Dr. Hermann completed an "intake" for the Petitioner on May 11, 2015. Dr. Hermann did not believe Petitioner required any further therapy based upon reported information from the Psychosocial History obtained, and from observation of the Petitioner. (PX 16, p. 185).

A Utilization Review report from Sedgwick, dated May 29, 2015, included a retro review of pain management measures provided by Dr. Abdellatif. This report was completed by Dr. Jeffrey Schiffman, a board-certified orthopedic specialist. The report indicates that the trigger point injections, bilateral medial branch blocks, bilateral facet blocks, the epidural steroid injection, and the epidurogram administered on December 3, 2014 were not medically necessary based upon ODG guidelines.

18IWCC0275

Additionally, Dr. Schiffman stated that the discogram, trigger point injection, epidural steroid injection, and the epidurogram administered on January 21, 2015 were not medically necessary based upon ODG guidelines. (RX 7).

Petitioner received ongoing treatment with Dr. Klepper through June 8, 2015. Her complaints in visits leading up to that date included pain at 7-8/10. (See PX 9, p. 550-587).

On June 10, 2015, Petitioner underwent anterior lumbar discectomy and fusion with insertion of anterior instrumentation from L4-S1. Post-operative diagnosis was lumbar pain. (PX 16, p. 170-171). Petitioner returned to Dr. Sokolowski on June 18, 2015. She was having difficulty sleeping due to postoperative back pain at night. Petitioner had been aggressively walking and felt optimistic that she would make substantial further improvement. Exam revealed some lumbar tenderness to palpation over the facet joints. Dr. Sokolowski prescribed Oxycontin and suggested she discontinue Norco. (PX 16, p. 164).

She next returned to Dr. Sokolowski on June 24, 2015 reporting that she was generally doing quite well. Petitioner had returned to taking Norco as needed and was pleased with her postoperative progress. Dr. Sokolowski recommended she "begin therapy in a couple of weeks" after she had "built up more endurance." She was directed to remain off work. (PX 16, p. 159).

Notes from Dr. Klepper indicate that Petitioner returned to that provider on June 29, 2015. At that time, she reported constant, severe bilateral lower back symptoms of generally achy but occasionally sharp nature. Her symptoms radiated from the bilateral lower back to the bilateral gluteal muscles. Petitioner rated her pain at 8/10. (PX 9, p.541).

Petitioner returned to Dr. Sokolowski on July 30, 2015. She had begun physical therapy and was making good progress. Petitioner reported back pain at 7/10 with radiating symptoms to her buttock and left thigh at 7/10. She exhibited mild lumbar paraspinal tenderness to palpation. Dr. Sokolowski recommended she remain off work to realize the benefit of continued physical therapy. (PX 16, p. 154). The following day, Petitioner presented to Dr. Larsen with a 3-day history of urinary frequency and urgency, with abdominal cramping. She stated that her back pain was improving status post-surgery. Dr. Larsen stated that her scripts would be filled by a pain clinic. (PX 22, p. 30).
Records from Petitioner's treatment with Dr. Klepper indicate that she continued visits with that provider three (3) times per week following the surgery. Her complaints of pain ranged from 7-9/10 during this time. A Reevaluation report from September 2, 2015 stated that Petitioner had constant moderate to severe bilateral lower back symptoms with radiating symptoms to her bilateral gluteals and into her left foot. (See PX 9, p. 404-461). Another Reevaluation report, from September 14, 2015, stated that Petitioner reported pain at 9/10. Exam revealed increase in muscle spasm. Active range of motion was painful and restricted. Petitioner noted that she had enrolled her daughter in First Communion classes which required her to sit for three (3) hours, resulting in an increase in her symptoms. (See PX 9, p. 380).

Petitioner returned to Dr. Sokolowski on September 15, 2015. She was doing quite well and was pleased with her progress. Dr. Sokolowski reviewed x-rays from August 24, 2015 which revealed no evidence of loosening or failure. There was no interbody fusion noted yet on the x-rays. Petitioner could remain off work to realize the benefit of continued therapy. (PX 16, p. 147).

18IWCC0275

A Utilization Review report from Sedgwick, dated September 16, 2015, included a retro review of chiropractic therapy provided by Dr. Klepper and Aarrow Healthcare from October 29, 2014 – August 27, 2015. This report was completed by Chiropractor Robert Kilroy. The report states that the records from Aarrow Healthcare show minimal to no subjective or objective improvement despite a reported 88 visits in less than one (1) year. Additionally, there was little to no change in the types of exercises performed, the repetitions performed, or the resistance used. As a result, this treatment was found not medically necessary. (RX 8).

Reports from Dr. Klepper's office show Petitioner continuing to attend visits at Aarrow Healthcare in September and October 2015. Her pain complaints during these visits consistently range between 7-8/10. Dr. Klepper's notes consistently state that Petitioner experienced "no significant change in symptoms." (See PX 9, p. 199-241, 276-374). Dr. Klepper authored a letter to Dr. Sokolowski, dated October 8, 2015, wherein he noted Petitioner's celiac problem, and requested that Dr. Sokolowski prescribe gluten free Vicodin to supplant Norco. (PX 16, p. 136). A Reevaluation report from Dr. Klepper, dated October 15, 2015, stated that Petitioner's stomach issues had been helped by the change in medication. She continued with symptoms 7-8/10. Petitioner exhibited painful and restricted AROM, and moderate to severe muscle hypertonicity. Dr. Klepper stated that Petitioner was progressing slower than expected. (PX 9, p. 180).

Petitioner last saw Dr. O'Keefe on October 16, 2015. She had undergone spine surgery on June 10, 2015 and stated that she was "happy with the surgery." Petitioner had experienced a "dramatic improvement in pain relief." She was still very sore and unable to walk long distances or carry significant loads. Going forward, Dr. Sokolowski would manage her medications and her work status. Clinical impression was "huge improvement in pain and limitation in motion just 4 months after surgery." Petitioner could continue exercises with Dr. Klepper, and consider possible exercises in a swimming pool in the next months. (PX 11, p. 16).

A note from Dr. Klepper, dated October 22, 2015, stated that Petitioner had experienced a severe exacerbation on October 10, 2015 when riding as a passenger in a vehicle in a construction zone. The car struck a bump, causing an increase in symptoms. (PX 9, p. 168).

Petitioner returned to Dr. Sokolowski on October 26, 2015 reporting an acute return of her lumbar pain after a short car trip. Her pain was severe, and Petitioner was concerned that she had experienced a functional setback. She rated her pain as an 8/10. Dr. Sokolowski refilled her Norco prescription and recommended updated x-rays. (PX 16, p. 128).

Petitioner continued regular treatment with Dr. Klepper in November 2015, with pain complaints regularly at 7/10. She continued to progress slower than expected. (See PX 9, p. 69-138). A Reevaluation report from November 23, 2015 stated that Petition no longer had complaints of stomach pain, which she attributed to her change in medication. She stated that she felt pain "for 75% of the day" and could "do less than 50% of the usual work." (PX 9, p. 53).

On November 23, 2015, Petitioner returned to Dr. Sokolowski reporting slow but steady progress in therapy. Her back pain was 8/10 with radiation to her left buttock, but not beyond. She felt significantly stronger than prior to surgery. X-ray from October 26, 2015 did not show an osseous union. Petitioner was weaning her Norco, and use of Medrox patches. Dr. Sokolowski recommended she use an external

18IWCC0275

bone stimulator to facilitate bony union. She was advised to remain off work pending clinical reevaluation. (PX 16, p. 120).

The notes from Dr. Klepper indicate that Petitioner last visited Aarrow Healthcare on December 3, 2015. At that time, she reported pain 6-7/10. She continued to progress slower than expected. (PX 9, p. 20). Dr. Klepper's records do not include any referral to any other physical therapy facility or provider.

On December 31, 2015, Petitioner presented to Dr. Ghanayem at Loyola University Medical Center for a third Section 12 examination. She continued to have ongoing low back pain, with persistent pain in the left buttock down the back of the thigh. Petitioner reported taking Norco three (3) times per day and Flexeril three (3) times per day for her pain. Exam revealed tenderness starting at T12 all the way to the sacrum. She exhibited low back pain with axial compression of the head, truncal rotation through the knees, and distraction through the shoulder. Light palpation caused her low back pain. Impression was residual low back pain after the two-level anterior lumbar fusion. She had subjective complaints of leg pain which Dr. Ghanayem could not substantiate. Dr. Ghanayem stated that he did not believe surgery was medically reasonable or necessary relative to the work injury. Her chiropractic care had been excessive and not medically reasonable or necessary. She still exhibited physical exam findings consistent with symptom magnification and nonorganic pain behaviors. Dr. Ghanayem stated that he felt Petitioner was at MMI when he last saw her in March 2015. At the time of the exam in December 2015, Dr. Ghanayem believed Petitioner could work light duty with a 15-20 pound lifting restriction, though he stated this restriction would not be related to her work injury. (RX 5). Dr. Ghanayem testified via evidence deposition on March 16, 2016. He testified that he is a board certified orthopedic surgeon, who is currently serving as the Chairman of the Department of Orthopedic Surgery at Loyola University Medical Center. The doctor estimated that he performed between 150 and 180 surgeries per year. (RX 6, p. 4-6). He stated that Petitioner's subjective complaints of back pain from the base of the lumbar spine all the way up to the thoracic spine, coupled with her subjective complaints of leg pain without evidence of neurologic compression on an MRI scan resulted in the contraindication for surgery. He further stated that Petitioner's "global symptoms" did not "match the disease process," and as a result of this "mismatch," he did not feel surgery was proper. (RX 6, p. 29-31).

Petitioner next returned to Dr. Sokolowski on March 14, 2016 reporting further functional progress. Petitioner was eager to begin transitioning to a home exercise program. She rated her back and buttock pain at 6/10 on this date. X-rays from January 19, 2016 showed satisfactory instrumentation with no evidence of loosening. There was not yet a solid interbody fusion. Dr. Sokolowski prescribed therapy once a week for the next six (6) to eight (8) weeks, with the remainder of her program to be self-directed. He also recommended an external bone stimulator to achieve a solid interbody fusion and obviate the need for posterior surgical management in the future. Petitioner could continue Norco and Flexeril and remain off work. (PX 16, p. 99).

Petitioner saw Dr. Sokolowski next on April 29, 2016. She had called for an urgent appointment due to the acute return of back pain with radiation to her left thigh, but not beyond her knee. Her back pain had slowly begun to diminish. Dr. Sokolowski recommended a Medrol Dose Pak and new x-rays of the lumbar spine. Petitioner could continue therapy. (PX 16, p. 92).

On May 12, 2016 Petitioner began treatment at Central DuPage Physical Medicine on May 12, 2016. Petitioner testified that she pursued care with this provider per a referral from Dr. Klepper, who was closing his practice. The medical records from Aarrow Healthcare and Central DuPage Physical

18IWCC0275

Medicine do not include any referrals or any indications as to how Petitioner arrived at Central DuPage Physical Medicine. Petitioner received chiropractic care from David Serrano, along with myofascial release and trigger point therapy, with supervised therapeutic exercises and interferential current stimulation. She was directed to return three (3) times per week. (PX 20, p. 8).

Petitioner presented to Central DuPage Hospital on May 25, 2016 with complaints of centralized abdominal pain. She had recently begun taking Mobic (two days ago) to control her chronic lower back pain. Petitioner advised she had been experiencing some aching left-sided pain "for several days." She had a past medical history significant for GERD, celiac disease, and mild ischemic colitis. Petitioner previously underwent colonoscopies and upper gastrointestinal endoscopies in 2015. She was diagnosed with mild recurring colitis, likely ischemic colitis. She was directed to stop Mobic and refrain from further anti-inflammatory use. (PX 6, p. 138-148)

Petitioner returned to Dr. Sokolowski on July 12, 2016. She reported that she completed "more aggressive" therapy, and felt she was making functional progress, with overall diminution in her pain scores. Her pain complaints on that date were 7/10 in the back and left thigh. Petitioner continued to use her external bone stimulator. CT scan from May 27, 2016 showed clear ossification developing within the interbody device. Dr. Sokolowski recommended continued therapy for six (6) to eight (8) weeks. She could remain off and plan to undergo an updated CT scan in November 2016. (PX 16, p. 77).

On November 15, 2016, Petitioner returned to Dr. Sokolowski reporting ongoing back pain at 7/10, with radiating to the legs and buttocks at 6/10. She continued to take Norco to control her pain. Petitioner noted increasing muscle spasm recently. CT of the lumbar spine from October 26, 2016 showed bone present at L4-5 and L5-S1. Dr. Sokolowski suspected that the fusion was present. He recommended that Petitioner see Dr. Lami for an independent second opinion evaluation. Dr. Sokolowski refilled her Flexeril for use with the muscle spasm. She was directed to remain off work. (PX 23).

Petitioner saw Dr. Babak Lami of the Illinois Spine Institute on November 23, 2016. She reported low back pain with radiation to her left buttock. Petitioner felt her spinal surgery had helped some of her symptoms. Dr. Lami reviewed Petitioner's CT scan and found evidence of fusion at L4-5 and L5-S1 with no loosening of hardware. There was enough evidence to conclude that L4-5 had fused. The L5-S1 level was not unstable. Dr. Lami stated that he would not recommend any surgery for her current symptoms. She could continue with pain management and a home exercise program. (PX 26).

On January 10, 2017, Petitioner saw Dr. Sokolowski. Her back pain and buttock pain was at 7/10. She had been increasing her home exercise program and noticed diminishing pain. Petitioner was taking one (1) Norco per day. Dr. Sokolowski felt she was likely at MMI postoperatively from her fusion surgery. She would likely have back pain indefinitely and could require a comprehensive pain management program to include home exercises, periodic courses of therapy, analgesics, and activity restrictions. Dr. Sokolowski advised Petitioner to remain off work until May 8, 2017. (PX 29).
Further notes from Central DuPage Physical Medicine include an "Interim Status Report/Treatment Plan" dated January 24, 2017. This report shows that Petitioner completed 89 visits in therapy, beginning on May 12, 2016. She reported a chief complaint of low back pain with intermittent leg pain, worse on the left side. Petitioner had felt 75% of her goals in terms of pain-free ARM, strength, and a return to daily activities. She could continue further treatment three (3) times per week for four (4) weeks. In the last daily note from the medical exhibit, on January 26, 2017, Petitioner reported low back pain at 8/10. (See PX 30).

18IWCC0275

A Sedgwick Utilization Review report from January 25, 2017 included a retro review of treatment provided by Dr. Serrano. This report was completed by Dr. Siva Ayyar, a board-certified occupational medicine specialist. Dr. Ayyar found that the 86 visits of chiropractic treatment and myofascial release from May 12, 2016 – January 11, 2017 were not medically necessary. The records failed to furnish a clear or compelling rationale for the prolonged, extensive manipulative therapy. Additionally, Dr. Ayyar found the trigger point injections administered by Dr. Serrano's office not medically necessary. The medical notes failed to outline evidence of functional improvement with multiple injections administered over the course of the claim. (RX 9).

Dr. Serrano's office appealed the UR report from January 25, 2017. Dr. Jeffrey Middledorf, a board-certified Physical Medicine and Rehabilitation specialist with an added expertise in Pain Medicine, authored a Utilization Review report dated February 9, 2017. Dr. Middledorf stated that an initial course of six (6) visits for chiropractic treatment would be appropriate. The remainder of the visits with Dr. Serrano were not medically necessary as the clinical visit notes showed no significant change in symptoms, or evidence of functional improvement. Additionally, Dr. Middledorf stated that the trigger point injections performed at Central DuPage Physical Medicine were not medically necessary.

At the time of the hearing, Petitioner testified that she felt stronger and more alert after undergoing surgery with Dr. Sokolowski. (Tr. 47-48). She testified that she hoped to go back to work when she was released by her doctors as she felt that she was "too young to stay home." (Tr. 48). Petitioner did admit that she is currently receiving Social Security Disability benefits. (Tr. 82).

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. In support of this finding, the Arbitrator relies on the medical evidence and the Petitioner's testimony. Specifically, the Arbitrator points out the issues of credibility, both in the live testimony as well as in the medical evidence. Although there is no dispute that the Petitioner sustained a back injury while working for the Respondent on November 2, 2013, the facts show that the issues arose in this case when Dr. Klepper inserted himself in this case after soliciting the Petitioner at her place of work and then taking over the management of Petitioner's medical care. Prior to Dr. Klepper's involvement in this case, all of the medical experts involved in Petitioner's claim: Dr. Larsen, Dr. Lee, Dr. Froese, Dr. Kolavo, Dr. McGivney were of the same opinion as Respondent's expert, Dr. Ghanayem that Petitioner was not a surgical candidate. After persuading Petitioner to see him, Dr. Klepper managed Petitioner's care by referring Petitioner to Dr. O'Keefe an orthopedic specialist, who essentially wrote prescriptions for Petitioner's medication, provided off work notes and also ordered the therapy to be performed by Dr. Klepper and Aarrow Healthcare. Despite being an orthopedic specialist, Dr. O'Keefe referred Petitioner to Dr. Sokolowski, another orthopedic specialist to perform Petitioner's surgery. Even more troubling is the fact that the medical evidence shows Petitioner continued to have complaints of back pain and continued to seek chiropractic care for her back following her surgery – all of which casts doubt on the efficacy of the surgery and supports the opinions of all of the Petitioner's prior medical providers: that Petitioner was not a surgical candidate. Dr. Klepper testified that part of his medical management of this case involved ordering all the Petitioner's medical records, presumably to have a better understanding of Petitioner's medical history – which would be reasonably expected in taking over the care of a patient who is possibly a surgical candidate. However, it was clear from the testimony of Dr. Klepper and Dr. O'Keefe that they either did not have Petitioner's prior medical records or failed to review the records prior to their testimony. Neither Dr. Klepper or Dr. O'Keefe could adequately address

18IWCC0275

the question of what Petitioner's diagnostic tests showed or whether her condition improved or deteriorated when comparing the tests taken at different times. Although Dr. Sokolowski testified that he believed there was a radiographic progression of her condition in the testing, the radiologists did not cite any worsening or progression in the MRI reports, with many of the reports citing findings similar to prior studies. Additionally, both Dr. Ghanayem and Dr. Sokolowski felt that the disc herniation seen at L5-S1in the 2011 MRI studies had reabsorbed in the studies after the 2013 accident. Dr. Sokolowski admitted that he could not definitively state whether the 2013 incident at Walgreens structurally altered her spine. (PX 18, p. 29-32).

Petitioner's testimony also raised questions regarding credibility. For example, Petitioner testified that when Dr. Klepper approached her in her store, she found him intimidating and she was not sure if he was really a doctor. Petitioner also testified that she was scared after meeting Dr. Klepper. Yet her actions clearly contradict her testimony as she willingly began her treatment with Dr. Klepper. Before she met Dr. Klepper, Petitioner was prescribed conservative treatment in the form of physical therapy and home exercises. The medical evidence shows that Petitioner was not compliant with this prescribed treatment. Additionally, Petitioner testified that she was terrified of undergoing surgery – yet she was willing to undergo surgery under the medical management of Dr. Klepper. Petitioner testified that her normal activities around the house did not aggravate her symptoms or complaints – which was directly rebutted by Dr. Klepper's medical records which show Petitioner's complaints were made worse due to activities of daily living. Finally, the Arbitrator notes that Petitioner testified that she did not wish to remain at home, and intended to return back to work, as she felt she was "too young to just be at home." (Tr. 39). However, Petitioner admitted that she has applied for, and is receiving, Social Security Disability benefits at present. (Tr. 82). Additionally, the records show that although Petitioner is now roughly 22 months removed from her surgery, and "likely" at MMI per Dr. Sokolowski in January 2017, yet she has not received, nor requested, any work release from any of her treating physicians.

Based on the issues of credibility with regard to the Petitioner's medical experts and Petitioner's own testimony, the Arbitrator finds persuasive the opinions of Petitioner's own medical experts who agreed with Respondent's IME, Dr. Ghanayem that Petitioner was not a surgical candidate and could have returned to work in some capacity. Given the inconsistencies noted above, coupled with the exam findings from Dr. Ghanayem suggesting the presence of nonorganic pain behaviors, the Arbitrator concludes that the Petitioner failed to prove that her current condition of ill being is causally related to her November 2, 2013 accident.

2. With regard to the issue of medical expenses and in accordance with the Arbitrator's conclusions with regard to the issue of causation, the Arbitrator awards the following medical expenses pursuant to the fee schedule:

The Arbitrator finds Respondent liable for the charges relating to Petitioner's April 3, 2014 visit with Dr. Larsen for back pain ($123.00 per PX 1), wherein Dr. Larsen provided Petitioner with a neurosurgical referral. The Arbitrator also finds Respondent liable for the charges relating to Dr. Lee's consultation on May 6, 2014 ($311.00 per PX 1).

18IWCC0275

Additionally, the Arbitrator finds Respondent liable for charges associated with Dr. Yang's pain management, including balances to Central DuPage Hospital ($6,331.75) and Dr. Yang ($3,193.00) for May 23, 2014, balances to Central DuPage Hospital ($6,331.75) and Dr. Yang ($1,442.40) for June 11, 2014, balances to Central DuPage Hospital ($6,337.25) and Dr. Yang ($2,884.00) for June 26, 2014, balances to Central DuPage Hospital ($335.50) and Dr. Yang ($309.00) for August 7, 2014, balances to Central DuPage Hospital ($9,873.75) and Dr. Yang ($4,352.00) for August 8, 2014, and Central DuPage Hospital ($9,868.00) and Dr. Yang ($3,296.00) for August 28, 2014 (all balances per PX 1).

The Arbitrator also finds Respondent liable for additional balances to Central DuPage Hospital, including MRI testing on May 28, 2014 ($3,982.75 per PX 1), a hospital visit on August 12, 2014 for left lower back pain after Petitioner's first ablation procedure ($1,515.00 per PX 1), a hospital visit on October 12, 2014 for pain across the whole lower back ($1,930.25 per PX 1), and visits on January 28, 2015 ($3,179.50 per PX 1) and January 31, 2015 ($10,797.75 per PX 1) for pain following the discogram procedure.

The Arbitrator finds Respondent liable for a visit to Dr. Larsen on September 26, 2014 for ongoing back pain, resulting in a referral to a physical medicine specialist ($123.00 per PX 1), and an October 25, 2014 visit with Dr. Corcoran for continued back pain following the ER visit on October 12 ($194.00 per PX 1).

The Arbitrator finds Respondent liable for the January 7, 2015 visit with Dr. O'Keefe ($159.83 per PX 1). The Arbitrator also finds Respondent liable for visits with Dr. Abdellatif on November 25, 2014 ($267.00 per PX 1), January 8, 2014 ($117.00 per PX 1), and February 13, 2015 ($117.00).

The Arbitrator finds Respondent liable for visits with Dr. Sokolowski which pre-date Dr. Ghanayem's March 5, 2015 IME opinion. This includes visits on December 17, 2014 ($367.00 per PX 1), February 2, 2015 ($295.00 per PX 1), and March 5, 2015 ($2,845.00 per PX 1).

Finally, the Arbitrator finds Respondent liable for the following radiology charges: Edgebrook MRI ($2,000.00 per PX 1) for January 21, 2015 services, and Winfield Radiology Group for May 28, 2014 services ($397.00 per PX 1), October 12, 2014 charges ($76.00 per PX 1), January 28, 2015 charges ($116.00 per PX 1), and January 31, 2015 ($592.00 per PX 1).

The Arbitrator finds that all medical treatment received after Dr. Ghanayem's March 5, 2015 IME report is not causally related to her work accident of November 2, 2013 (or her work accident of January 27, 2011). In support of denial of other charges placed into evidence by Petitioner, the Arbitrator notes the following:

The Petitioner did not place any records into evidence detailing the treatment received, or supporting causal connection between her work injury and the May 5, 2014 visit at Central DuPage Hospital ($1,283.00 per PX 1). Petitioner's visit to Central DuPage Hospital on May 25, 2016 ($10,503.00 per PX 1) related to abdominal pain, with the records referencing Petitioner's pre-existing history of GERD, celiac disease, and mild ischemic colitis. She was diagnosed with mild recurring colitis at the time of this visit. (PX 6, p. 138-148). The Arbitrator finds that the charges for this visit are not causally related to Petitioner's work injury with Walgreens.

The Arbitrator finds that the Respondent is not liable for charges to Dr. Larsen for date of service May 4, 2015 ($194.00 per PX 1). The records show that Petitioner presented to this provider in follow up from a

18IWCC0275

hospital visit in April for colitis that required Petitioner to undergo a colonoscopy. (PX 22, p. 26). Additionally, the Arbitrator finds that Petitioner is not liable for a visit to Dr. Larsen on July 31, 2015 ($194.00 per PX 1). Dr. Larsen's records indicate that this visit related a 3-days history of urinary frequency and urgency, with abdominal cramping. (PX 22, p. 30). The Arbitrator finds that these complaints, and the treatment received, were not causally related to Petitioner's work injury with the Respondent.

Although Petitioner's Medical Bill Exhibit suggests that Respondent made minimal payments to Aarrow Healthcare, payment information from Respondent's insurance carrier states that Respondent paid $10,426.23 to that provider, corresponding with dates of service from October 29, 2014 (the commencement of Petitioner's treatment with Dr. Klepper) through March 2, 2015. (RX 1). In addition to relying upon Dr. Ghanayem's IME report of March 5, 2015 for denial of further treatment after that date, the Arbitrator notes that the Utilization Review report of September 16, 2015 stated Dr. Klepper's treatment did not represent medically necessary care. The report cited the fact that Petitioner demonstrated "minimal to no subjective or objective improvement" during the course of her treatment with Dr. Klepper. (RX 8). The Arbitrator notes that the treating medical records of Dr. Klepper also indicate that Petitioner's subjective pain complaints did not show consistent, measurable improvement. The Arbitrator points to the Functional Capacity Evaluation of March 27, 2015, which identified a "lack of improvement with physical therapy." (PX 9, p. 608-612). Additionally, the Arbitrator notes that Dr. Klepper failed to convincingly support the efficacy of his treatment course during his deposition testimony, and admitted to his prior felony conviction for lying on a police report, thereby calling into question his credibility. Dr. Klepper's medical exhibits also include letters accusing Walgreens of discriminatory practices against Hispanic employees, and characterizing the opinions of Dr. Ghanayem as "poppycock." Additionally, the Arbitrator notes that Dr. O'Keefe admitted during his deposition that he was not receiving chart notes from Dr. Klepper detailing the care Petitioner was receiving prior to surgery with Dr. Sokolowski. He also admitted that he could not specify the exact treatment Petitioner received from Dr. Klepper. (PX 12, p. 50-51). Dr. Sokolowski also testified that although he received records from Dr. Klepper's treatment, he did not call Klepper to discuss Petitioner's care, and was not ordering or providing direction to either O'Keefe or Klepper regarding the type of treatment Petitioner received from Klepper. (PX 18, p. 66-68). Based upon this evidence, the Arbitrator finds that Respondent is not liable for any medical expenses from Dr. Klepper.

The Arbitrator finds that Respondent is not liable for any outstanding charges relating to Dr. Abdellatif's pain management procedures on December 3, 2014. The Arbitrator points to the Utilization Review report of May 29, 2015 which indicates the trigger point injections, medial branch blocks, and epidural steroid injection were not medically necessary. (RX 7). Additionally, the Arbitrator notes that the medical evidence, including the deposition testimony of Petitioner's treating physician Dr. Sokolowski, states that Petitioner was not suffering from true radicular pain following the November 2013 work accident. As noted in the Utilization Review report, radiculopathy was not noted on exam or documented in diagnostic imaging. Both Dr. Ghanayem and Dr. Sokolowski testified that Petitioner exam and MRIs failed to show any evidence of neural compression. As a result, Respondent is not liable for any remaining balances for the December 3, 2014 date of service.

Similarly, the Arbitrator finds that Respondent is not liable for any remaining balances for the January 21, 2015 date of service, including charges relating to the injections Petitioner received from Dr. Abdellatif in conjunction with the discogram. The Arbitrator notes that the May 29, 2015 Utilization

18IWCC0275

Report suggests that all treatment rendered on this date, including the discogram, did not represent medically necessary treatment. Specifically, the Arbitrator notes that Petitioner received an epidural steroid injection at L4-5 on January 21, 2015. Once again, the Arbitrator finds that any charges relating to an epidural injection on this date are not medically necessary. The medical evidence shows that Petitioner was not suffering from any radiculopathy or any neural compression.

The Arbitrator finds that Respondent is not liable for treatment provided to Petitioner by Dr. Serrano and Central DuPage Physical Medicine. Although Petitioner testified that she has treated in physical therapy continuously since the time of her surgery in June 2015, the medical records placed into evidence suggest that she last treated with Dr. Klepper in December 2015 and did not begin treatment with Dr. Serrano until May 2016. As there are no medical records supporting treatment between December 3, 2015 and May 12, 2016, Respondent is not liable for any medical balances for any physical therapy or chiropractic treatment that may have been rendered between December 3, 2015 and May 12, 2016.

In addition to relying upon the IME opinion of Dr. Ghanayem finding Petitioner at MMI as of March 5, 2015, the Arbitrator finds the Utilization Review reports from Sedgwick persuasive in determining that the treatment provided by Dr. Serrano and Central DuPage Physical Medicine was not medically necessary. In the January 23, 2017 Utilization Review report, Dr. Ayyar stated that there was "no clear or compelling rationale" for the prolonged and extensive therapy received by the Petitioner. Additionally, the report cited the "absence of functional improvement" in the records of Dr. Serrano. Dr. Ayyar also stated that the trigger point injections received by Petitioner were not medically necessary as Petitioner failed to show any evidence of objective improvement during the course of her treatment with this provider. (RX 9). The second report, completed in response to Dr. Serrano's appeal on February 9, 2017, cited similar arguments in support of the finding that this treatment was not medically necessary. (RX 10). The Arbitrator notes that a review of Petitioner's extensive treatment with Dr. Serrano suggests that Petitioner attended therapy with this provider three (3) times per week for more than eight (8) months, up until the date of the hearing. The records fail to show any clear evidence of consistent objective or functional improvement. Additionally, the Arbitrator notes that the records indicate Petitioner began receiving adjustments and mobilization therapy to her upper lumbar and thoracic spine on or about August 24, 2016. (PX 20, p. 47). The records show that Petitioner has continued to receive chiropractic adjustments to these areas through the date of the hearing. Petitioner testified that she was receiving "adjustments to my neck" from Dr. Serrano. (Tr. 79). Based upon this evidence, the Arbitrator finds the treatment rendered by Dr. Serrano and Central DuPage Physically Medicine not medically reasonable and/or necessary.

Additionally, the Arbitrator notes that the medical evidence does not include any referral from any of Petitioner's treating providers to Dr. Serrano or any other provider at Central DuPage Physical Medicine for therapy/chiropractic care. Petitioner testified that Dr. Klepper directed her to Dr. Serrano, but neither Dr. Klepper's records, nor those of Dr. Serrano, include any evidence confirming this chain of referral. As a result, the Arbitrator finds that Petitioner exceeded her two (2) choices of treating physician in opting to pursue therapy/chiropractic care with Central DuPage Physical Medicine. The Arbitrator notes that Petitioner regularly sought treatment with Dr. Larsen (her primary care provider), who served as her "first choice" of treating physician. Dr. Klepper served as Petitioner's "second choice" when she chose to begin treating with that provider after meeting him at Walgreens.

With respect to any further medical charges, the Arbitrator finds all treatment rendered after the March 5, 2015 IME of Dr. Ghanayem not causally related to Petitioner's work accident with Walgreens.

18IWCC0275

3. With regard to the issue of TTD, the Arbitrator finds that the Petitioner is entitled to TTD benefits from October 12, 2014 through October 20, 2014, corresponding with the off work recommendation she received from the providers at Central DuPage Hospital (on October 12, 2014), and from Dr. Corcoran, who removed Petitioner from work until her evaluation by Dr. Froese on October 20, 2014. At the time of Petitioner's visit on October 20, 2014, Dr. Froese recommended that Petitioner return to work with no lifting greater than 15 pounds for two 92) weeks, transitioning to full duties thereafter. (PX 8, p. 12-14, RX 2). Although Petitioner relies upon the opinions of Drs. Klepper and O'Keefe in arguing that she is entitled to further TTD benefits beginning on October 29, 2014, her first visit with Dr. Klepper at Aarrow Healthcare, the Arbitrator is not persuaded by the medical evidence in support of Petitioner's claim for any additional TTD.

4. Based on the Arbitrator's conclusions above, the Arbitrator further finds that the Petitioner's request for prospective medical treatment is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rafael Morales,
Petitioner,
vs.

NO: 13WC 33963

18IWCC0276

Home Slyce Wheel House,
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, notice, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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: MAY 4 - 2018
o050118
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORALES, RAFAEL
Employee/Petitioner

Case# **13WC033963**

HOME SLYCE WHEEL HOUSE
Employer/Respondent

18IWCC0276

On 5/4/2017, 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 0.97% 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:

3149 LAW OFFICE OF NICHOLIS J STEIN
83 W MAIN ST
SUITE 200
LAKE ZURICH, IL 60047

2837 LAW OFFICE OF JOSEPH MARCINIAK
NICOLE S McNAIR
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rafael Morales
Employee/Petitioner

v.

Home Slyce Wheel House
Employer/Respondent

Case # **13 WC 33963**

Consolidated cases: _____

18IWCC0276

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 **April 12, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☒ Was timely notice of the accident given to Respondent?

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

G. ☒ What were Petitioner's earnings?

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

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

J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☒ TTD

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

M. ☒ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

18IWCC0276

On **August 1, 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 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 $**16,380.00**; the average weekly wage was $**315.00**.

On the date of accident, Petitioner was **25** 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 $**0** under Section 8(j) of the Act.

ORDER

Petitioner failed to credibly prove that a work-related injury arose out of and in the course of Petitioner's employment with Respondent on August 1, 2013 and therefore 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

05-02-17
Date

MAY 4 - 2017

STATE OF ILLINOIS)
)
COUNTY OF Cook)

18IWCC0276

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rafael Morales,
Employee/Petitioner

Case # 13 WC 33963

v.

Chicago

Home Slyce Wheel House,
Employers/Respondents

Findings of Facts and Conclusions of Law

An Application for Adjustment of Claim was filed in this matter. The case was heard by the Honorable Kurt Carlson, Arbitrator of the Workers' Compensation Commission, in the city of Chicago, on April 12, 2017. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. Findings of Fact

The Petitioner, Rafael Garcia a/k/a Morales, was employed as a line cook/"pizza guy" at Homeslice on August 1, 2013. On that date, Petitioner claims that he injured his low back, right hip and right leg when he fell down the stairs while carrying a box of tomatoes on his right shoulder downstairs to the cooler. Petitioner testified that he fell when he was almost to the bottom of the stairs and he fell back into a sitting position so that part of his buttocks and back were on the stairs. Petitioner testified that he stood up, picked up the tomatoes and brought them to the cooler and continued to work with pain in his right hip and leg. Petitioner testified that he told the head chef, Luis Manzo, a few hours later that he had fallen and was in a little pain. The injury was not generally reported Petitioner continued to work without issue for seven weeks.

Petitioner first sought treatment on September 18, 2013 at H and M Medical. (Px. 3). Petitioner reported on the "Request for Treatment" form that on August 1, 2013, he went downstairs to the cooler at work to pick up some products and fell on the stairs and twisted his back. However, in the Initial Evaluation, it is noted that on August 1, 2013, Petitioner bent to pick up a box of tomatoes weighing approximately 30 lbs. and felt a sharp pain in his low back.

(Px. 3). There is no mention of a fall on the stairs. In his initial report, Eric Ruble, DC notes that on August 1, 2013, Petitioner walked down the stairs to pick up a box of tomatoes and felt a sharp pain in his low back while picking up and carrying the box. (Px. 3). Again, there is no mention of a fall on the stairs. Dr. Ruble indicates that Petitioner had been to the hospital on August 28, 2013 and received an injection and Norco. (Px. 3). Records of this alleged hospital visit were not presented as evidence. The September 20, 2013 work status note from H and M Medical, which places light duty restrictions on Petitioner, indicates a September 18, 2013 date of injury. (Px. 3).

Petitioner testified that September 18, 2013 was the last day he worked at Homeslice. He testified that he went to Homeslice the following day, September 19, 2013, to get a written report of the injury as requested by H and M Medical. Petitioner testified that on that date, he spoke to sous chef Juan Palacio and told him that he needed to fill out a report about the accident that could be sent to the insurance company. Petitioner testified that Mr. Palacio helped him make out the report. Petitioner wrote the report in Spanish and Mr. Palacio translated the report into English. (Px. 6, Rx. 1). Mr. Palacio advised Petitioner that he would give the report to the owner.

Juan Palacio also testified at the hearing. Mr. Palacio was the sous (assistant) chef at Homeslice in August and September 2013. He testified that he was in charge of the restaurant and employees, including line cooks like Petitioner, if the head chef Luis Manzo, was not there. Mr. Palacio testified that the first time he heard that Petitioner was claiming an injury on August 1, 2013 was on September 24, 2013 when Petitioner came to him asking to make a report of the injury. Mr. Palacio testified that Petitioner had been working without issue until September 24, 2013. Mr. Palacio stated that Petitioner wrote a description of the accident in Spanish (Rx. 1) and then Mr. Palacio translated that report into English (Px. 6). Mr. Palacio testified that he gave the report to the owner, Josh, on the same day.

Petitioner underwent chiropractic treatment from September 20, 2013 through October 7, 2013. (Px. 3). On September 22, 2013, Petitioner presented to the Emergency Department at Mt. Sinai Hospital complaining of right buttock and leg pain for one month after twisting knee, increased for three days. (Px. 2). The History and Physical Exam Worksheet indicates that symptoms all began after patient suffered a trip with twisting of right hip. (Px. 2). On October 7, 2013, Petitioner underwent a lumbar MRI, which demonstrated a L5-S1 right central/subarticular herniation measuring approximately 7.5mm compromising the thecal sac and the right S1 nerve root with inner margin compromise of the right foramen, an L4-5 4.4mm central disc herniation

with annular tear and L3-4 disc bulging. (Px. 2). Dr. Ruble referred Petitioner to Dr. Krishna Chunduri, also at H and M Medical, for pain management. (Px. 3). On October 11, 2013, Dr. Chunduri indicates that Petitioner reported that he was going down the stairs on August 1, 2013 carrying boxes when he slipped and fell on his back hitting the stair. (Px. 3). Petitioner reported he got up and continued to carry the boxes up the stairs when the pain started to increase. (Px. 3). Dr. Chunduri recommended a right L5-S1 epidural steroid injection, medications and physical therapy. (Px. 3). Petitioner continued chiropractic treatment with Dr. Ruble. (Px. 3). On October 16, 2013, Petitioner underwent the right L5-S1 transforaminal ESI. (Px. 4). On October 25, 2013, Dr. Chunduri noted mild improvement and referred Petitioner to a spine surgeon. (Px. 3). Petitioner continued chiropractic treatment with Dr. Ruble until November 6, 2013. (Px. 3).

On November 19, 2013, Petitioner presented to the Emergency Department at Mt. Sinai Hospital after he woke up that morning with severe low back pain with radiation down his right leg. (Px. 2). A lumbar MRI on that date demonstrated a very large central right paracentral and right lateral disc protrusion and extrusion at L5-S1 with severe central and right foraminal stenosis and compression of the thecal sac and adjacent nerve roots and a small central disc protrusion at L4-5 with associated annular fissure. (Px. 2). Petitioner was admitted to the hospital and, on November 21, 2013, was seen by Dr. Sturgill who noted 5 months of right lower extremity pain with progressive weakness. (Px. 2). Petitioner reported being off work since August 2013. (Px. 2). Dr. Sturgill diagnosed L5 radiculopathy with motor weakness and indicated there was an absolute indication for surgery. (Px. 2). On November 22, 2013, Petitioner underwent a right-sided L5-S1 hemilaminectomy and discectomy with fairly significant large facetectomy at L5-S1, due to the large nature of the disk with bone chips reapplied into the facet joint area for arthrodesis for 1-segement fusion. (Px. 2). On November 24, 2013, Petitioner was discharged from Mt. Sinai Hospital. (Px. 2). Petitioner was to follow-up with Dr. Sturgill in two weeks, but there is no indication of any follow-up in the admitted exhibits.

Petitioner testified that he went back to work in a packing company, Stampede Meat, on December 25, 2013 (Petitioner claims he is owed TTD through December 24, 2013). Petitioner has worked steadily since then. He testified that his back, right hip and right leg are better since the surgery, but still bother him from time to time. Petitioner testified that he does exercise for the leg, which is what helps it the most.

II. Conclusions of Law

Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? What was the date of the accident?

The Arbitrator finds that an accident did not occur arising out of and in the course of Petitioner's employment by Respondent. Petitioner's testimony that he sustained a work-related injury on August 1, 2013 is not credible due to a variety of factors.

First, Petitioner provided varying descriptions of the injury to the medical providers. On September 18, 2013, H and M Medical providers noted a variety of descriptions of the alleged accident including (1) he went downstairs to the cooler at work to pick up some products and fell on the stairs and twisted his back; (2) he bent to pick up a box of tomatoes weighing approximately 30 lbs. and felt a sharp pain in his low back; and (3) he felt a sharp pain in his low back while picking up and carrying the box. Petitioner confirmed that the providers at H and M Medical spoke Spanish and there was no issue with communication. On September 22, 2013, Petitioner described to the Emergency Department at Mt. Sinai Hospital that symptoms all began after he suffered a trip with twisting of right hip. Petitioner provided another description of the accident to Dr. Chunduri on October 11, 2013 that he was going down the stairs carrying boxes when he slipped and fell on his back hitting the stair. Petitioner sometimes described the injury as a fall on the stairs and sometimes as solely a lifting injury. The fact that Petitioner did not consistently describe the accident to providers is not credible.

Second, Petitioner did not seek treatment for seven weeks after the accident. It is not credible that Petitioner sustained such a serious disc injury on August 1, 2013, which eventually required surgery, and did not seek treatment for seven weeks.

Third, during those seven weeks, Petitioner worked without issue at Homeslice. Juan Palacio, one of Petitioner's managers, testified that he did not notice any issues with Petitioner's work during that time. Further, Mr. Palacio was unaware that Petitioner sustained an injury until it was reported to him on September 24, 2013. It is not credible that Petitioner could have sustained such a serious disc issue on August 1, 2013 and work without issue for seven weeks.

The Arbitrator finds that it is not credible that Petitioner sustained a work-related accident on August 1, 2013. Petitioner's descriptions of the accident to medical providers varied. He did not seek treatment for the alleged accident for seven weeks and worked without issue during that time. The Arbitrator finds Petitioner's testimony that an accident occurred on August 1, 2013 is not credible. Therefore, the Arbitrator finds that an accident did not occur arising out

of and in the course of Petitioner's employment by Respondent.

Was timely notice of the accident given to Respondent?

The Arbitrator finds that timely notice of the accident was not given to Respondent. Petitioner reported the injury to Respondent on September 24, 2013 as indicated on the accident report Petitioner wrote in Spanish. The Illinois Workers' Compensation Act requires the Petitioner to notify his employer of an accident within 45 days. Mr. Palacio (petitioner's supervisor and manager of the pizzeria) testified that the report was not made until September 24, 2013, which is ten days after the statutory deadline. Further, Palacio's testimony was corroborated by the medical records of H and M Medical, who advised the Petitioner to make a written report by that facility. Therefore, the Arbitrator finds that timely notice of the alleged August 1, 2013 accident was not given to Respondent.

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

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to a work-related injury as Petitioner did not credibly prove that a work-related injury arose out of and in the course of Petitioner's employment with Respondent on August 1, 2013.

What were Petitioner's earnings?

Respondent presented Petitioner's wage statement demonstrating Petitioner's weeks and hours worked, which was objected to by Petitioner and sustained. Petitioner testified that he earned $9/hour and worked full time. Mr. Palacio testified that line cooks, including Petitioner, worked full time approximately 35 hours per week. The Arbitrator therefore finds that Petitioner's earnings during the year preceding the injury were $16,380.00, and the average weekly wage, calculated pursuant to Section 10 of the Act, was $315.00.

Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator finds that the medical services provided to Petitioner were not reasonable

and necessary for a work-related injury as Petitioner did not credibly prove that a work-related injury arose out of and in the course of Petitioner's employment with Respondent on August 1, 2013.

What temporary benefits are in dispute? TTD?

The Arbitrator finds that Petitioner is not entitled to any TTD for a work-related injury as Petitioner did not credibly prove that a work-related injury arose out of and in the course of Petitioner's employment with Respondent on August 1, 2013.

What is the nature and extent of the injury?

The Arbitrator finds that Petitioner is not entitled to any permanent partial disability for a work-related injury as Petitioner did not credibly prove that a work-related injury arose out of and in the course of Petitioner's employment with Respondent on August 1, 2013.

Should penalties or fees be imposed upon Respondent?

The Arbitrator finds that penalties and fees should not be imposed upon Respondent. There has not been any unreasonable or vexatious delay of payment or intentional underpayment of compensation. Respondent had a valid reason for denying payment of all benefits under this claim. Therefore, the Arbitrator finds that penalties and fees are not appropriate.

Arbitrator Kurt Carlson

05-02-17

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

Dolores Mendoza,
Petitioner,
vs.

NO: 09WC 8670

18IWCC0277

Kelloggs's Company,
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 permanent partial disability, temporary total disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 6, 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAY 4 - 2018
o050118
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, DOLORES
Employee/Petitioner

Case# **09WC008670**

09WC008671
09WC008672
10WC023866
10WC023867
11WC000215

KELLOG'S COMPANY
Employer/Respondent

18IWCC0277

On 10/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN FISHMAN BENDER ETAL
ART GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

18IWCC0277

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

DOLORES MENDOZA
Employee/Petitioner

v.

KELLOGG'S COMPANY
Employer/Respondent

Case # **09** WC **8670**

Consolidated cases:
09 WC 8671, 09 WC 8672
10WC23866, 10WC23867, 11WC215

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 **March 21, 2016 and July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 7, 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.

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 **$27,976.00**; the average weekly wage was **$538.00**.

On the date of accident, Petitioner was **54** years of age, **married**, with **no** dependent children.

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

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

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

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

ORDER

The Arbitrator further finds that the Petitioner did not sustain any permanent partial disability as a result of the work accident on March 7, 2008.

The Arbitrator does not award any medical bills per the attached memorandum of decision incorporated herein.

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

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

Milton Black

Signature of Arbitrator

October 6, 2016
Date

ICArbDec p. 2

OCT 6 - 2016

FACTS

Case #10 WC 23866 and Case #10 WC 23867

Petitioner voluntarily dismissed these two cases at the commencement of the hearing.

Prior Back Problems

Petitioner has a history of back pain and treatment dating back to 2005. (Resp. Ex. 1) Petitioner was diagnosed with and received treatment for thoracic and lumbar conditions in 2005. During cross-examination Petitioner initially denied any prior treatment for back pain but then admitted that she treated with Dr. Bialowas, her primary care physician, for back pain before 2008. (Arb. Tr. at 42).

On August 7, 2007, Petitioner presented to St. Anthony's Hospital with complaints of back pain that radiated and worsened with certain movements of her left shoulder. (Resp. Ex. 4). Petitioner reported at that time that she had been feeling left sided back pain for two months prior and did not indicate a specific incident that caused the pain. *Id.*

March 7, 2008 Accident

Petitioner was working for Respondent when she alleges an injury to her lower back on March 7, 2008. Petitioner testified that she was lifting trays weighing approximately 20 pounds. (Arb. Tr. at 18). Petitioner was treated at Concentra and was diagnosed with a lumbosacral strain. (Resp. Ex. 1). Petitioner underwent physical therapy until her release from care on March 19, 2008. *Id.* Petitioner had no lost time and continued to work her regular duties after her March 7, 2008 accident. (Arb. Tr. at 19).

September 12, 2008 Accident

Petitioner testified that she injured her low back again on September 12, 2008 as she was lifting trays of candy. Petitioner was transported to St. Anthony's Hospital where she was diagnosed with back pain (Pet. Ex.18). She continued to treat with her primary care physician, Dr. Bialowas. (Arb. Tr. 21). Petitioner presented to Concentra on February 3, 2009 with complaints about her back. (Resp. Ex. 1). Petitioner testified that she injured her back as she was lifting a tray that had candy stuck on the bottom. *Id.* Petitioner sustained no lost time and continued to work her regular duties after her September 12, 2008 accident. (Arb. Tr. at 22).

January 24, 2009 Accident

Petitioner alleges that she was lifting trays of sweets to empty at a machine and a coworker pulled a tray away from her which resulted in Petitioner's left index finger being bent. (Arb. Tr. 46). X-rays performed on January 31, 2009 were negative for fracture. (Pet. Ex. 16). Petitioner was seen by Dr. Bialowa, who prescribed her physical therapy and light duty. (Resp. Ex. 1). Petitioner presented to Concentra on February 3, 2009. *Id.* At Concentra she was diagnosed with a finger sprain and released her from care on February 3, 2009. *Id.* Petitioner continued to work her regular duties after her January 24, 2009 accident. *Id.*

June 4, 2010 Accident

Petitioner alleges a fourth accident took place on June 4, 2010. Petitioner's testimony on direct examination regarding this particular alleged accident was as follows:

Mr. German: Now, could you describe to the Judge how you injured yourself on that date?
Petitioner: On that day, they had me emptying out the sweet on two different bands when there are usually two persons for that, and they had me do it by myself. When I finished with the sweets, the pallets contained 22 trays, and you have to empty them in each band in less than a half an hour. When I was not able to keep up, then I would place them here.
Arbitrator: Where is here?
Petitioner: Here. In my back. On my back.
Arbitrator: The witness is indicating from where I'm sitting both shoulders and her upper back. Is that what you're seeing, gentlemen?
Mr. Carlson: Yes
Mr. German: Yes.

Petitioner testified that the trays weighed 20 to 30 pounds. (Arb. Tr. 26). Petitioner testified to pain in her upper and low back, neck, and left shoulder with numbness into both legs. *Id.* Petitioner presented to Concentra on June 11, 2010 giving a history of back pain symptoms while working. (Resp. Ex. 1). Petitioner was treated conservatively for a lumbar strain and was placed at full duty. On June 25, 2010 Petitioner was placed at MMI by Dr. Paloyan. Petitioner continued to work full duty without any lost time.

Petitioner went to Dr. Bialowas and Midwest Medicorp for physical therapy. (Resp. Ex. 2). An MRI of the lumbar spine dated August 5, 2010, revealed disk desiccation at L5-S1 with slight facet arthropathy at the L5-S1 without any evidence of disk herniation, spinal stenosis, or impingement. *Id* Petitioner began chiropractic treatment with La Clinica *Id.* While she was given a 10 pound working restriction, she continued to do her regular work. (Arb. Tr. 28-29). An MRI of the thoracic spine dated July 12, 2011 revealed mid thoracic degenerative disk disease without herniated disks, spinal stenosis, or other abnormalities. (Resp. Ex. 2). Petitioner underwent an FCE through WorkWell on August 9, 2011. (Resp. Ex. 5). The FCE found that Petitioner's performance was inconsistent. *Id.* Petitioner demonstrated improved range of motion in her upper extremities during functional testing in comparison to formal range of motion testing. *Id.* Petitioner demonstrated improved lower extremity strength and endurance during functional tasks compared to formal testing. *Id.* During the exam, Petitioner refused to attempt greater than fifteen pounds for front carry despite no medical indications to stop the testing. *Id.* Petitioner exhibited a slow pace with multiple gait abnormalities and refused to crouch to complete a task. *Id.* The FCE report concluded that Petitioner's claimed functional limitations were not consistent with physical impairments or diagnosis and that her perceived abilities were below those objectively identified in the FCE. The FCE evaluator was unable to assess a return to work due to physical problems other than the referred diagnosis of lumbar, thoracic and cervical pain as well as due to the self-limited performance by Petitioner.

Respondent submitted surveillance of Petitioner. (Resp. Ex. 7). On July 5, 2010, Petitioner was seen sweeping, watering plants, bending, squatting, pushing a grocery cart containing grocery bags, as well as lifting and carrying the bags,

Dr. Michael Kornblatt performed an IME on Petitioner on December 5, 2011. (Resp. Ex 2). He noted a past history significant for periodic chronic episodes of back pain dating back to 2005. *Id.* Dr. Kornblatt opined that Petitioner suffered a work-related lumbosacral strain. *Id.* His examination of Petitioner was consistent with deconditioned state and a psychogenic component to pain complaints. *Id.* Dr. Kornblatt opined that Petitioner reached maximum medical improvement three months post-injury and did not need thoracic or lumbar spine surgery. Dr. Kornblatt opined that Petitioner could initially return to work with a 20 pound lifting restriction and

then without restrictions over the next four to six weeks. *Id.* The final diagnoses were chronic dysfunction myofascial pain and degenerative disk disease that were unrelated to the alleged work accident. *Id.*

On February 11, 2013, Dr. Kornblatt performed a record review and drafted an addendum. (Resp. Ex. 3). Dr. Kornblatt reviewed the results of the FCE conducted on August 9, 2011 and opined that it was invalid. *Id.* Dr. Kornblatt ultimately concluded that his opinions remain as stated in his December 5, 2011 IME report. *Id.* As stated in that report, Petitioner sustained a lumbosacral strain as a result of the alleged work accident and reached MMI/full duty without restrictions by September 4, 2010. *Id.*

Petitioner continued to work her regular job until she was terminated on May 26, 2011. (Arb Tr. 50) Petitioner testified that she would have and could have continued in her regular job duties had she not been terminated. (Arb Tr. 50)

ACCIDENT AND CAUSATION

The Arbitrator finds that Petitioner sustained a temporary exacerbation of a degenerative back condition as indicated by the Concentra records, FCE, MRI and Dr. Kornblatt. Petitioner continued to work full duty without lost time and would have continued to do so, by her own testimony, if her job had not ended. The medical history records support a pre-existing degenerative back condition dating back to 2005. Petitioner testified that she had treated for back pain with Dr. Bialowas before her first claimed accident of March 7, 2008. Medical records from St. Anthony's Hospital report that Petitioner had complained of back pain in 2007 that was not attributed to any particular event. The 2010 and 2011 MRIs revealed spine degenerative changes without any evidence of disk injuries. The FCE in August of 2011 was inconsistent, invalid and self-limiting with perceived limitations beyond the objective medical findings.

The Arbitrator is persuaded by Dr. Kornblatt's opinion that Petitioner's diagnoses of chronic pain dysfunction-myofascial pain syndrome and lumbar and thoracic disk disease are unrelated to the alleged work accidents. The Arbitrator finds that the temporary exacerbation and back strain ended by June 25, 2010 and that Petitioner returned to her baseline state and was full duty and MMI from any work injury as of June 25, 2010. Any medical treatment and complaints of symptoms after June 25, 2010 are not related to any of the alleged work accidents.

NATURE AND EXTENT

March 7, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of March 19, 2008 and finds that there was no permanency from this accident.

September 12, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of two weeks and finds that there was no permanency from this accident.

January 24, 2009

The Arbitrator finds that Petitioner sustained a finger strain with no lost time. Petitioner was at MMI within two weeks. Petitioner testified that she feels some numbness in her finger when she extends it. Based upon the foregoing, the Arbitrator awards 5% loss of use of the left index finger.

June 4, 2010

The Arbitrator finds that Petitioner sustained a slight exacerbation back strain with no lost time. The Arbitrator finds that Petitioner was full duty as of June 11, 2010 and MMI as of June 25, 2010. Based upon the foregoing, the Arbitrator awards 2% of the person as a whole.

TTD AND MEDICAL

Based upon the previous findings no TTD is awarded and no medical bills are awarded.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dolores Mendoza,
Petitioner,
vs.

NO: 09WC 8671

18IWCC0278

Kelloggs's Company,
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 permanent partial disability, temporary total disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 6, 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAY 4 - 2018
o050118
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, DOLORES
Employee/Petitioner

KELLOG'S COMPANY
Employer/Respondent

Case# **09WC008671**

09WC008670
09WC008672
10WC023866
10WC023867
11WC000215

18IWCC0278

On 10/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN FISHMAN BENDER ETAL
ART GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

18IWCC0278

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

DOLORES MENDOZA
Employee/Petitioner

v.

KELLOGG'S COMPANY
Employer/Respondent

Case # **09** WC **8671**

Consolidated cases:
09 WC 8670, 09 WC 8672
10WC23866, 10WC23867, 11WC215

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 **March 21, 2016 and July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, 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.

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 **$27,976.00**; the average weekly wage was **$538.00**.

On the date of accident, Petitioner was **54** years of age, **married**, with **no** dependent children.

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

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

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

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

ORDER

The Arbitrator further finds that the Petitioner did not sustain any permanent partial disability as a result of the work accident on September 12, 2008.

The Arbitrator does not award any medical bills per the attached memorandum of decision incorporated herein.

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

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

Signature of Arbitrator

October 6, 2016
Date

ICArbDec p. 2

OCT 6 - 2016

FACTS

Case #10 WC 23866 and Case #10 WC 23867

Petitioner voluntarily dismissed these two cases at the commencement of the hearing.

Prior Back Problems

Petitioner has a history of back pain and treatment dating back to 2005. (Resp. Ex. 1) Petitioner was diagnosed with and received treatment for thoracic and lumbar conditions in 2005. During cross-examination Petitioner initially denied any prior treatment for back pain but then admitted that she treated with Dr. Bialowas, her primary care physician, for back pain before 2008. (Arb. Tr. at 42).

On August 7, 2007, Petitioner presented to St. Anthony's Hospital with complaints of back pain that radiated and worsened with certain movements of her left shoulder. (Resp. Ex. 4). Petitioner reported at that time that she had been feeling left sided back pain for two months prior and did not indicate a specific incident that caused the pain. *Id.*

March 7, 2008 Accident

Petitioner was working for Respondent when she alleges an injury to her lower back on March 7, 2008. Petitioner testified that she was lifting trays weighing approximately 20 pounds. (Arb. Tr. at 18). Petitioner was treated at Concentra and was diagnosed with a lumbosacral strain. (Resp. Ex. 1). Petitioner underwent physical therapy until her release from care on March 19, 2008. *Id.* Petitioner had no lost time and continued to work her regular duties after her March 7, 2008 accident. (Arb. Tr. at 19).

September 12, 2008 Accident

Petitioner testified that she injured her low back again on September 12, 2008 as she was lifting trays of candy. Petitioner was transported to St. Anthony's Hospital where she was diagnosed with back pain (Pet. Ex.18). She continued to treat with her primary care physician, Dr. Bialowas. (Arb. Tr. 21). Petitioner presented to Concentra on February 3, 2009 with complaints about her back. (Resp. Ex. 1). Petitioner testified that she injured her back as she was lifting a tray that had candy stuck on the bottom. *Id.* Petitioner sustained no lost time and continued to work her regular duties after her September 12, 2008 accident. (Arb. Tr. at 22).

January 24, 2009 Accident

Petitioner alleges that she was lifting trays of sweets to empty at a machine and a coworker pulled a tray away from her which resulted in Petitioner's left index finger being bent. (Arb. Tr. 46). X-rays performed on January 31, 2009 were negative for fracture. (Pet. Ex. 16). Petitioner was seen by Dr. Bialowa, who prescribed her physical therapy and light duty. (Resp. Ex. 1). Petitioner presented to Concentra on February 3, 2009. *Id.* At Concentra she was diagnosed with a finger sprain and released her from care on February 3, 2009. *Id.* Petitioner continued to work her regular duties after her January 24, 2009 accident. *Id.*

June 4, 2010 Accident

Petitioner alleges a fourth accident took place on June 4, 2010. Petitioner's testimony on direct examination regarding this particular alleged accident was as follows:

Mr. German: Now, could you describe to the Judge how you injured yourself on that date?
Petitioner: On that day, they had me emptying out the sweet on two different bands when there are usually two persons for that, and they had me do it by myself. When I finished with the sweets, the pallets contained 22 trays, and you have to empty them in each band in less than a half an hour. When I was not able to keep up, then I would place them here.
Arbitrator: Where is here?
Petitioner: Here. In my back. On my back.
Arbitrator: The witness is indicating from where I'm sitting both shoulders and her upper back. Is that what you're seeing, gentlemen?
Mr. Carlson: Yes
Mr. German: Yes.

Petitioner testified that the trays weighed 20 to 30 pounds. (Arb. Tr. 26). Petitioner testified to pain in her upper and low back, neck, and left shoulder with numbness into both legs. *Id.* Petitioner presented to Concentra on June 11, 2010 giving a history of back pain symptoms while working. (Resp. Ex. 1). Petitioner was treated conservatively for a lumbar strain and was placed at full duty. On June 25, 2010 Petitioner was placed at MMI by Dr. Paloyan. Petitioner continued to work full duty without any lost time.

Petitioner went to Dr. Bialowas and Midwest Medicorp for physical therapy. (Resp. Ex. 2). An MRI of the lumbar spine dated August 5, 2010, revealed disk desiccation at L5-S1 with slight facet arthropathy at the L5-S1 without any evidence of disk herniation, spinal stenosis, or impingement. *Id* Petitioner began chiropractic treatment with La Clinica *Id.* While she was given a 10 pound working restriction, she continued to do her regular work. (Arb. Tr. 28-29). An MRI of the thoracic spine dated July 12, 2011 revealed mid thoracic degenerative disk disease without herniated disks, spinal stenosis, or other abnormalities. (Resp. Ex. 2). Petitioner underwent an FCE through WorkWell on August 9, 2011. (Resp. Ex. 5). The FCE found that Petitioner's performance was inconsistent. *Id.* Petitioner demonstrated improved range of motion in her upper extremities during functional testing in comparison to formal range of motion testing. *Id.* Petitioner demonstrated improved lower extremity strength and endurance during functional tasks compared to formal testing. *Id.* During the exam, Petitioner refused to attempt greater than fifteen pounds for front carry despite no medical indications to stop the testing. *Id.* Petitioner exhibited a slow pace with multiple gait abnormalities and refused to crouch to complete a task. *Id.* The FCE report concluded that Petitioner's claimed functional limitations were not consistent with physical impairments or diagnosis and that her perceived abilities were below those objectively identified in the FCE. The FCE evaluator was unable to assess a return to work due to physical problems other than the referred diagnosis of lumbar, thoracic and cervical pain as well as due to the self-limited performance by Petitioner.

Respondent submitted surveillance of Petitioner. (Resp. Ex. 7). On July 5, 2010, Petitioner was seen sweeping, watering plants, bending, squatting, pushing a grocery cart containing grocery bags, as well as lifting and carrying the bags,

Dr. Michael Kornblatt performed an IME on Petitioner on December 5, 2011. (Resp. Ex 2). He noted a past history significant for periodic chronic episodes of back pain dating back to 2005. *Id.* Dr. Kornblatt opined that Petitioner suffered a work-related lumbosacral strain. *Id.* His examination of Petitioner was consistent with deconditioned state and a psychogenic component to pain complaints. *Id.* Dr. Kornblatt opined that Petitioner reached maximum medical improvement three months post-injury and did not need thoracic or lumbar spine surgery. Dr. Kornblatt opined that Petitioner could initially return to work with a 20 pound lifting restriction and

then without restrictions over the next four to six weeks. *Id.* The final diagnoses were chronic dysfunction myofascial pain and degenerative disk disease that were unrelated to the alleged work accident. *Id.*

On February 11, 2013, Dr. Kornblatt performed a record review and drafted an addendum. (Resp. Ex. 3). Dr. Kornblatt reviewed the results of the FCE conducted on August 9, 2011 and opined that it was invalid. *Id.* Dr. Kornblatt ultimately concluded that his opinions remain as stated in his December 5, 2011 IME report. *Id.* As stated in that report, Petitioner sustained a lumbosacral strain as a result of the alleged work accident and reached MMI/full duty without restrictions by September 4, 2010. *Id.*

Petitioner continued to work her regular job until she was terminated on May 26, 2011. (Arb Tr. 50) Petitioner testified that she would have and could have continued in her regular job duties had she not been terminated. (Arb Tr. 50)

ACCIDENT AND CAUSATION

The Arbitrator finds that Petitioner sustained a temporary exacerbation of a degenerative back condition as indicated by the Concentra records, FCE, MRI and Dr. Kornblatt. Petitioner continued to work full duty without lost time and would have continued to do so, by her own testimony, if her job had not ended. The medical history records support a pre-existing degenerative back condition dating back to 2005. Petitioner testified that she had treated for back pain with Dr. Bialowas before her first claimed accident of March 7, 2008. Medical records from St. Anthony's Hospital report that Petitioner had complained of back pain in 2007 that was not attributed to any particular event. The 2010 and 2011 MRIs revealed spine degenerative changes without any evidence of disk injuries. The FCE in August of 2011 was inconsistent, invalid and self-limiting with perceived limitations beyond the objective medical findings.

The Arbitrator is persuaded by Dr. Kornblatt's opinion that Petitioner's diagnoses of chronic pain dysfunction-myofascial pain syndrome and lumbar and thoracic disk disease are unrelated to the alleged work accidents. The Arbitrator finds that the temporary exacerbation and back strain ended by June 25, 2010 and that Petitioner returned to her baseline state and was full duty and MMI from any work injury as of June 25, 2010. Any medical treatment and complaints of symptoms after June 25, 2010 are not related to any of the alleged work accidents.

NATURE AND EXTENT

March 7, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of March 19, 2008 and finds that there was no permanency from this accident.

September 12, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of two weeks and finds that there was no permanency from this accident.

January 24, 2009

The Arbitrator finds that Petitioner sustained a finger strain with no lost time. Petitioner was at MMI within two weeks. Petitioner testified that she feels some numbness in her finger when she extends it. Based upon the foregoing, the Arbitrator awards 5% loss of use of the left index finger.

June 4, 2010

The Arbitrator finds that Petitioner sustained a slight exacerbation back strain with no lost time. The Arbitrator finds that Petitioner was full duty as of June 11, 2010 and MMI as of June 25, 2010. Based upon the foregoing, the Arbitrator awards 2% of the person as a whole.

TTD AND MEDICAL

Based upon the previous findings no TTD is awarded and no medical bills are awarded.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dolores Mendoza,
Petitioner,
vs.

NO: 09WC 8672

18IWCC0279

Kelloggs's Company,
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 permanent partial disability, temporary total disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 6, 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 $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: MAY 4 - 2018
o050118
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, DOLORES
Employee/Petitioner

Case# **09WC008672**

09WC008670
09WC008671
10WC023866
10WC023867
11WC000215

KELLOG'S COMPANY
Employer/Respondent

18IWCC0279

On 10/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN FISHMAN BENDER ETAL
ART GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

18IWCC0279

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

DOLORES MENDOZA
Employee/Petitioner

v.

KELLOGG'S COMPANY
Employer/Respondent

Case # **09** WC **8672**

Consolidated cases:
09 WC 8670, 09 WC 8671
10WC23866, 10WC23867, 11WC215

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 **March 21, 2016 and July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 24, 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 $**27,976.00**; the average weekly wage was $**538.00**.

On the date of accident, Petitioner was **55** years of age, **married**, with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **322.80**/week for **2.15** weeks, because the injuries sustained caused the **5%** loss use of the **left index finger**, as provided in Section 8(e) of the Act.

The Arbitrator does not award any medical bills per the attached memorandum of decision incorporated herein.

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

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

Signature of Arbitrator

October 6, 2016
Date

ICArbDec p. 2

OCT 6 - 2016

FACTS

Case #10 WC 23866 and Case #10 WC 23867

Petitioner voluntarily dismissed these two cases at the commencement of the hearing.

Prior Back Problems

Petitioner has a history of back pain and treatment dating back to 2005. (Resp. Ex. 1) Petitioner was diagnosed with and received treatment for thoracic and lumbar conditions in 2005. During cross-examination Petitioner initially denied any prior treatment for back pain but then admitted that she treated with Dr. Bialowas, her primary care physician, for back pain before 2008. (Arb. Tr. at 42).

On August 7, 2007, Petitioner presented to St. Anthony's Hospital with complaints of back pain that radiated and worsened with certain movements of her left shoulder. (Resp. Ex. 4). Petitioner reported at that time that she had been feeling left sided back pain for two months prior and did not indicate a specific incident that caused the pain. *Id.*

March 7, 2008 Accident

Petitioner was working for Respondent when she alleges an injury to her lower back on March 7, 2008. Petitioner testified that she was lifting trays weighing approximately 20 pounds. (Arb. Tr. at 18). Petitioner was treated at Concentra and was diagnosed with a lumbosacral strain. (Resp. Ex. 1). Petitioner underwent physical therapy until her release from care on March 19, 2008. *Id.* Petitioner had no lost time and continued to work her regular duties after her March 7, 2008 accident. (Arb. Tr. at 19).

September 12, 2008 Accident

Petitioner testified that she injured her low back again on September 12, 2008 as she was lifting trays of candy. Petitioner was transported to St. Anthony's Hospital where she was diagnosed with back pain (Pet. Ex.18). She continued to treat with her primary care physician, Dr. Bialowas. (Arb. Tr. 21). Petitioner presented to Concentra on February 3, 2009 with complaints about her back. (Resp. Ex. 1). Petitioner testified that she injured her back as she was lifting a tray that had candy stuck on the bottom. *Id.* Petitioner sustained no lost time and continued to work her regular duties after her September 12, 2008 accident. (Arb. Tr. at 22).

January 24, 2009 Accident

Petitioner alleges that she was lifting trays of sweets to empty at a machine and a coworker pulled a tray away from her which resulted in Petitioner's left index finger being bent. (Arb. Tr. 46). X-rays performed on January 31, 2009 were negative for fracture. (Pet. Ex. 16). Petitioner was seen by Dr. Bialowa, who prescribed her physical therapy and light duty. (Resp. Ex. 1). Petitioner presented to Concentra on February 3, 2009. *Id.* At Concentra she was diagnosed with a finger sprain and released her from care on February 3, 2009. *Id.* Petitioner continued to work her regular duties after her January 24, 2009 accident. *Id.*

June 4, 2010 Accident

Petitioner alleges a fourth accident took place on June 4, 2010. Petitioner's testimony on direct examination regarding this particular alleged accident was as follows:

Mr. German: Now, could you describe to the Judge how you injured yourself on that date?
Petitioner: On that day, they had me emptying out the sweet on two different bands when there are usually two persons for that, and they had me do it by myself. When I finished with the sweets, the pallets contained 22 trays, and you have to empty them in each band in less than a half an hour. When I was not able to keep up, then I would place them here.
Arbitrator: Where is here?
Petitioner: Here. In my back. On my back.
Arbitrator: The witness is indicating from where I'm sitting both shoulders and her upper back. Is that what you're seeing, gentlemen?
Mr. Carlson: Yes
Mr. German: Yes.

Petitioner testified that the trays weighed 20 to 30 pounds. (Arb. Tr. 26). Petitioner testified to pain in her upper and low back, neck, and left shoulder with numbness into both legs. *Id.* Petitioner presented to Concentra on June 11, 2010 giving a history of back pain symptoms while working. (Resp. Ex. 1). Petitioner was treated conservatively for a lumbar strain and was placed at full duty. On June 25, 2010 Petitioner was placed at MMI by Dr. Paloyan. Petitioner continued to work full duty without any lost time.

Petitioner went to Dr. Bialowas and Midwest Medicorp for physical therapy. (Resp. Ex. 2). An MRI of the lumbar spine dated August 5, 2010, revealed disk desiccation at L5-S1 with slight facet arthropathy at the L5-S1 without any evidence of disk herniation, spinal stenosis, or impingement. *Id* Petitioner began chiropractic treatment with La Clinica *Id.* While she was given a 10 pound working restriction, she continued to do her regular work. (Arb. Tr. 28-29). An MRI of the thoracic spine dated July 12, 2011 revealed mid thoracic degenerative disk disease without herniated disks, spinal stenosis, or other abnormalities. (Resp. Ex. 2). Petitioner underwent an FCE through WorkWell on August 9, 2011. (Resp. Ex. 5). The FCE found that Petitioner's performance was inconsistent. *Id.* Petitioner demonstrated improved range of motion in her upper extremities during functional testing in comparison to formal range of motion testing. *Id.* Petitioner demonstrated improved lower extremity strength and endurance during functional tasks compared to formal testing. *Id.* During the exam, Petitioner refused to attempt greater than fifteen pounds for front carry despite no medical indications to stop the testing. *Id.* Petitioner exhibited a slow pace with multiple gait abnormalities and refused to crouch to complete a task. *Id.* The FCE report concluded that Petitioner's claimed functional limitations were not consistent with physical impairments or diagnosis and that her perceived abilities were below those objectively identified in the FCE. The FCE evaluator was unable to assess a return to work due to physical problems other than the referred diagnosis of lumbar, thoracic and cervical pain as well as due to the self-limited performance by Petitioner.

Respondent submitted surveillance of Petitioner. (Resp. Ex. 7). On July 5, 2010, Petitioner was seen sweeping, watering plants, bending, squatting, pushing a grocery cart containing grocery bags, as well as lifting and carrying the bags,

Dr. Michael Kornblatt performed an IME on Petitioner on December 5, 2011. (Resp. Ex 2). He noted a past history significant for periodic chronic episodes of back pain dating back to 2005. *Id.* Dr. Kornblatt opined that Petitioner suffered a work-related lumbosacral strain. *Id.* His examination of Petitioner was consistent with deconditioned state and a psychogenic component to pain complaints. *Id.* Dr. Kornblatt opined that Petitioner

reached maximum medical improvement three months post-injury and did not need thoracic or lumbar spine surgery. Dr. Kornblatt opined that Petitioner could initially return to work with a 20 pound lifting restriction and then without restrictions over the next four to six weeks. *Id.* The final diagnoses were chronic dysfunction myofascial pain and degenerative disk disease that were unrelated to the alleged work accident. *Id.*

On February 11, 2013, Dr. Kornblatt performed a record review and drafted an addendum. (Resp. Ex. 3). Dr. Kornblatt reviewed the results of the FCE conducted on August 9, 2011 and opined that it was invalid. *Id.* Dr. Kornblatt ultimately concluded that his opinions remain as stated in his December 5, 2011 IME report. *Id.* As stated in that report, Petitioner sustained a lumbosacral strain as a result of the alleged work accident and reached MMI/full duty without restrictions by September 4, 2010. *Id.*

Petitioner continued to work her regular job until she was terminated on May 26, 2011. (Arb Tr. 50) Petitioner testified that she would have and could have continued in her regular job duties had she not been terminated. (Arb Tr. 50)

ACCIDENT AND CAUSATION

The Arbitrator finds that Petitioner sustained a temporary exacerbation of a degenerative back condition as indicated by the Concentra records, FCE, MRI and Dr. Kornblatt. Petitioner continued to work full duty without lost time and would have continued to do so, by her own testimony, if her job had not ended. The medical history records support a pre-existing degenerative back condition dating back to 2005. Petitioner testified that she had treated for back pain with Dr. Bialowas before her first claimed accident of March 7, 2008. Medical records from St. Anthony's Hospital report that Petitioner had complained of back pain in 2007 that was not attributed to any particular event. The 2010 and 2011 MRIs revealed spine degenerative changes without any evidence of disk injuries. The FCE in August of 2011 was inconsistent, invalid and self-limiting with perceived limitations beyond the objective medical findings.

The Arbitrator is persuaded by Dr. Kornblatt's opinion that Petitioner's diagnoses of chronic pain dysfunction-myofascial pain syndrome and lumbar and thoracic disk disease are unrelated to the alleged work accidents. The Arbitrator finds that the temporary exacerbation and back strain ended by June 25, 2010 and that Petitioner returned to her baseline state and was full duty and MMI from any work injury as of June 25, 2010. Any medical treatment and complaints of symptoms after June 25, 2010 are not related to any of the alleged work accidents.

NATURE AND EXTENT

March 7, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of March 19, 2008 and finds that there was no permanency from this accident.

September 12, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent

injury. The Arbitrator finds that Petitioner was full duty and MMI as of two weeks and finds that there was no permanency from this accident.

January 24, 2009

The Arbitrator finds that Petitioner sustained a finger strain with no lost time. Petitioner was at MMI within two weeks. Petitioner testified that she feels some numbness in her finger when she extends it. Based upon the foregoing, the Arbitrator awards 5% loss of use of the left index finger.

June 4, 2010

The Arbitrator finds that Petitioner sustained a slight exacerbation back strain with no lost time. The Arbitrator finds that Petitioner was full duty as of June 11, 2010 and MMI as of June 25, 2010. Based upon the foregoing, the Arbitrator awards 2% of the person as a whole.

TTD AND MEDICAL

Based upon the previous findings no TTD is awarded and no medical bills are awarded.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dolores Mendoza,
Petitioner,
vs.

NO: 10WC 23866

18IWCC0280

Kelloggs's Company,
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 permanent partial disability, temporary total disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 6, 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAY 4 - 2018
o050118
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, DELORES
Employee/Petitioner

Case# **10WC023866**

09WC008670
09WC008671
09WC008672
10WC023867
11WC000215

KELLOGG'S COMPANY
Employer/Respondent

18IWCC0280

On 10/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
ART GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

18IWCC0280

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

DOLORES MENDOZA
Employee/Petitioner

v.

KELLOGG'S COMPANY
Employer/Respondent

Case # **10WC23866**

Consolidated cases:
09 WC 8670, 09 WC 8671
09 WC 8672, 10WC23867, 11WC215

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 **March 21, 2016 and July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 _____

ORDER

Petitioner voluntarily dismissed this case at the commencement of the hearing.

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

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

Milton Black

Signature of Arbitrator

October 6, 2016
Date

ICArbDec p. 2

OCT 6 - 2016

FACTS

Case #10 WC 23866 and Case #10 WC 23867

Petitioner voluntarily dismissed these two cases at the commencement of the hearing.

Prior Back Problems

Petitioner has a history of back pain and treatment dating back to 2005. (Resp. Ex. 1) Petitioner was diagnosed with and received treatment for thoracic and lumbar conditions in 2005. During cross-examination Petitioner initially denied any prior treatment for back pain but then admitted that she treated with Dr. Bialowas, her primary care physician, for back pain before 2008. (Arb. Tr. at 42).

On August 7, 2007, Petitioner presented to St. Anthony's Hospital with complaints of back pain that radiated and worsened with certain movements of her left shoulder. (Resp. Ex. 4). Petitioner reported at that time that she had been feeling left sided back pain for two months prior and did not indicate a specific incident that caused the pain. *Id.*

March 7, 2008 Accident

Petitioner was working for Respondent when she alleges an injury to her lower back on March 7, 2008. Petitioner testified that she was lifting trays weighing approximately 20 pounds. (Arb. Tr. at 18). Petitioner was treated at Concentra and was diagnosed with a lumbosacral strain. (Resp. Ex. 1). Petitioner underwent physical

therapy until her release from care on March 19, 2008. *Id.* Petitioner had no lost time and continued to work her regular duties after her March 7, 2008 accident. (Arb. Tr. at 19).

September 12, 2008 Accident

Petitioner testified that she injured her low back again on September 12, 2008 as she was lifting trays of candy. Petitioner was transported to St. Anthony's Hospital where she was diagnosed with back pain (Pet. Ex.18). She continued to treat with her primary care physician, Dr. Bialowas. (Arb. Tr. 21). Petitioner presented to Concentra on February 3, 2009 with complaints about her back. (Resp. Ex. 1). Petitioner testified that she injured her back as she was lifting a tray that had candy stuck on the bottom. *Id.* Petitioner sustained no lost time and continued to work her regular duties after her September 12, 2008 accident. (Arb. Tr. at 22).

January 24, 2009 Accident

Petitioner alleges that she was lifting trays of sweets to empty at a machine and a coworker pulled a tray away from her which resulted in Petitioner's left index finger being bent. (Arb. Tr. 46). X-rays performed on January 31, 2009 were negative for fracture. (Pet. Ex. 16). Petitioner was seen by Dr. Bialowa, who prescribed her physical therapy and light duty. (Resp. Ex. 1). Petitioner presented to Concentra on February 3, 2009. *Id.* At Concentra she was diagnosed with a finger sprain and released her from care on February 3, 2009. *Id.* Petitioner continued to work her regular duties after her January 24, 2009 accident. *Id.*

June 4, 2010 Accident

Petitioner alleges a fourth accident took place on June 4, 2010. Petitioner's testimony on direct examination regarding this particular alleged accident was as follows:

Mr. German: Now, could you describe to the Judge how you injured yourself on that date?
Petitioner: On that day, they had me emptying out the sweet on two different bands when there are usually two persons for that, and they had me do it by myself. When I finished with the sweets, the pallets contained 22 trays, and you have to empty them in each band in less than a half an hour. When I was not able to keep up, then I would place them here.
Arbitrator: Where is here?
Petitioner: Here. In my back. On my back.
Arbitrator: The witness is indicating from where I'm sitting both shoulders and her upper back. Is that what you're seeing, gentlemen?
Mr. Carlson: Yes
Mr. German: Yes.

Petitioner testified that the trays weighed 20 to 30 pounds. (Arb. Tr. 26). Petitioner testified to pain in her upper and low back, neck, and left shoulder with numbness into both legs. *Id.* Petitioner presented to Concentra on June 11, 2010 giving a history of back pain symptoms while working. (Resp. Ex. 1). Petitioner was treated conservatively for a lumbar strain and was placed at full duty. On June 25, 2010 Petitioner was placed at MMI by Dr. Paloyan. Petitioner continued to work full duty without any lost time.

Petitioner went to Dr. Bialowas and Midwest Medicorp for physical therapy. (Resp. Ex. 2). An MRI of the lumbar spine dated August 5, 2010, revealed disk desiccation at L5-S1 with slight facet arthropathy at the L5-S1 without any evidence of disk herniation, spinal stenosis, or impingement. *Id* Petitioner began chiropractic

treatment with La Clinica *Id.* While she was given a 10 pound working restriction, she continued to do her regular work. (Arb. Tr. 28-29). An MRI of the thoracic spine dated July 12, 2011 revealed mid thoracic degenerative disk disease without herniated disks, spinal stenosis, or other abnormalities. (Resp. Ex. 2). Petitioner underwent an FCE through WorkWell on August 9, 2011. (Resp. Ex. 5). The FCE found that Petitioner's performance was inconsistent. *Id.* Petitioner demonstrated improved range of motion in her upper extremities during functional testing in comparison to formal range of motion testing. *Id.* Petitioner demonstrated improved lower extremity strength and endurance during functional tasks compared to formal testing. *Id.* During the exam, Petitioner refused to attempt greater than fifteen pounds for front carry despite no medical indications to stop the testing. *Id.* Petitioner exhibited a slow pace with multiple gait abnormalities and refused to crouch to complete a task. *Id.* The FCE report concluded that Petitioner's claimed functional limitations were not consistent with physical impairments or diagnosis and that her perceived abilities were below those objectively identified in the FCE. The FCE evaluator was unable to assess a return to work due to physical problems other than the referred diagnosis of lumbar, thoracic and cervical pain as well as due to the self-limited performance by Petitioner.

Respondent submitted surveillance of Petitioner. (Resp. Ex. 7). On July 5, 2010, Petitioner was seen sweeping, watering plants, bending, squatting, pushing a grocery cart containing grocery bags, as well as lifting and carrying the bags,

Dr. Michael Kornblatt performed an IME on Petitioner on December 5, 2011. (Resp. Ex 2). He noted a past history significant for periodic chronic episodes of back pain dating back to 2005. *Id.* Dr. Kornblatt opined that Petitioner suffered a work-related lumbosacral strain. *Id.* His examination of Petitioner was consistent with deconditioned state and a psychogenic component to pain complaints. *Id.* Dr. Kornblatt opined that Petitioner reached maximum medical improvement three months post-injury and did not need thoracic or lumbar spine surgery. Dr. Kornblatt opined that Petitioner could initially return to work with a 20 pound lifting restriction and then without restrictions over the next four to six weeks. *Id.* The final diagnoses were chronic dysfunction myofascial pain and degenerative disk disease that were unrelated to the alleged work accident. *Id.*

On February 11, 2013, Dr. Kornblatt performed a record review and drafted an addendum. (Resp. Ex. 3). Dr. Kornblatt reviewed the results of the FCE conducted on August 9, 2011 and opined that it was invalid. *Id.* Dr. Kornblatt ultimately concluded that his opinions remain as stated in his December 5, 2011 IME report. *Id.* As stated in that report, Petitioner sustained a lumbosacral strain as a result of the alleged work accident and reached MMI/full duty without restrictions by September 4, 2010. *Id.*

Petitioner continued to work her regular job until she was terminated on May 26, 2011. (Arb Tr. 50) Petitioner testified that she would have and could have continued in her regular job duties had she not been terminated. (Arb Tr. 50)

ACCIDENT AND CAUSATION

The Arbitrator finds that Petitioner sustained a temporary exacerbation of a degenerative back condition as indicated by the Concentra records, FCE, MRI and Dr. Kornblatt. Petitioner continued to work full duty without lost time and would have continued to do so, by her own testimony, if her job had not ended. The medical history records support a pre-existing degenerative back condition dating back to 2005. Petitioner testified that she had treated for back pain with Dr. Bialowas before her first claimed accident of March 7, 2008. Medical records from St. Anthony's Hospital report that Petitioner had complained of back pain in 2007 that was not attributed to any particular event. The 2010 and 2011 MRIs revealed spine degenerative changes

without any evidence of disk injuries. The FCE in August of 2011 was inconsistent, invalid and self-limiting with perceived limitations beyond the objective medical findings.

The Arbitrator is persuaded by Dr. Kornblatt's opinion that Petitioner's diagnoses of chronic pain dysfunction-myofascial pain syndrome and lumbar and thoracic disk disease are unrelated to the alleged work accidents. The Arbitrator finds that the temporary exacerbation and back strain ended by June 25, 2010 and that Petitioner returned to her baseline state and was full duty and MMI from any work injury as of June 25, 2010. Any medical treatment and complaints of symptoms after June 25, 2010 are not related to any of the alleged work accidents.

NATURE AND EXTENT

March 7, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of March 19, 2008 and finds that there was no permanency from this accident.

September 12, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of two weeks and finds that there was no permanency from this accident.

January 24, 2009

The Arbitrator finds that Petitioner sustained a finger strain with no lost time. Petitioner was at MMI within two weeks. Petitioner testified that she feels some numbness in her finger when she extends it. Based upon the foregoing, the Arbitrator awards 5% loss of use of the left index finger.

June 4, 2010

The Arbitrator finds that Petitioner sustained a slight exacerbation back strain with no lost time. The Arbitrator finds that Petitioner was full duty as of June 11, 2010 and MMI as of June 25, 2010. Based upon the foregoing, the Arbitrator awards 2% of the person as a whole.

TTD AND MEDICAL

Based upon the previous findings no TTD is awarded and no medical bills are awarded.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dolores Mendoza,
Petitioner,
vs.

NO: 10WC 23867

18IWCC0281

Kelloggs's Company,
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 permanent partial disability, temporary total disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 6, 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAY 4 – 2018
o050118
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, DELORES
Employee/Petitioner

Case# **10WC023867**

09WC008670
09WC008671
09WC008672
10WC023866
11WC000215

KELLOGG'S COMPANY
Employer/Respondent

18IWCC0281

On 10/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
ART GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
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

DOLORES MENDOZA
Employee/Petitioner

v.

KELLOGG'S COMPANY
Employer/Respondent

Case # **10WC23867**

Consolidated cases:
09 WC 8670, 09 WC 8671
09 WC 8672, 10WC23866, 11WC215

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 **March 21, 2016 and July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 _____

ORDER

Petitioner voluntarily dismissed this case at the commencement of the hearing.

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

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

Milton Black

Signature of Arbitrator

October 6, 2016
Date

ICArbDec p. 2

OCT 6 - 2016

FACTS

Case #10 WC 23866 and Case #10 WC 23867

Petitioner voluntarily dismissed these two cases at the commencement of the hearing.

Prior Back Problems

Petitioner has a history of back pain and treatment dating back to 2005. (Resp. Ex. 1) Petitioner was diagnosed with and received treatment for thoracic and lumbar conditions in 2005. During cross-examination Petitioner initially denied any prior treatment for back pain but then admitted that she treated with Dr. Bialowas, her primary care physician, for back pain before 2008. (Arb. Tr. at 42).

On August 7, 2007, Petitioner presented to St. Anthony's Hospital with complaints of back pain that radiated and worsened with certain movements of her left shoulder. (Resp. Ex. 4). Petitioner reported at that time that she had been feeling left sided back pain for two months prior and did not indicate a specific incident that caused the pain. *Id.*

March 7, 2008 Accident

Petitioner was working for Respondent when she alleges an injury to her lower back on March 7, 2008. Petitioner testified that she was lifting trays weighing approximately 20 pounds. (Arb. Tr. at 18). Petitioner was treated at Concentra and was diagnosed with a lumbosacral strain. (Resp. Ex. 1). Petitioner underwent physical

therapy until her release from care on March 19, 2008. *Id.* Petitioner had no lost time and continued to work her regular duties after her March 7, 2008 accident. (Arb. Tr. at 19).

September 12, 2008 Accident

Petitioner testified that she injured her low back again on September 12, 2008 as she was lifting trays of candy. Petitioner was transported to St. Anthony's Hospital where she was diagnosed with back pain (Pet. Ex.18). She continued to treat with her primary care physician, Dr. Bialowas. (Arb. Tr. 21). Petitioner presented to Concentra on February 3, 2009 with complaints about her back. (Resp. Ex. 1). Petitioner testified that she injured her back as she was lifting a tray that had candy stuck on the bottom. *Id.* Petitioner sustained no lost time and continued to work her regular duties after her September 12, 2008 accident. (Arb. Tr. at 22).

January 24, 2009 Accident

Petitioner alleges that she was lifting trays of sweets to empty at a machine and a coworker pulled a tray away from her which resulted in Petitioner's left index finger being bent. (Arb. Tr. 46). X-rays performed on January 31, 2009 were negative for fracture. (Pet. Ex. 16). Petitioner was seen by Dr. Bialowa, who prescribed her physical therapy and light duty. (Resp. Ex. 1). Petitioner presented to Concentra on February 3, 2009. *Id.* At Concentra she was diagnosed with a finger sprain and released her from care on February 3, 2009. *Id.* Petitioner continued to work her regular duties after her January 24, 2009 accident. *Id.*

June 4, 2010 Accident

Petitioner alleges a fourth accident took place on June 4, 2010. Petitioner's testimony on direct examination regarding this particular alleged accident was as follows:

Mr. German: Now, could you describe to the Judge how you injured yourself on that date?
Petitioner: On that day, they had me emptying out the sweet on two different bands when there are usually two persons for that, and they had me do it by myself. When I finished with the sweets, the pallets contained 22 trays, and you have to empty them in each band in less than a half an hour. When I was not able to keep up, then I would place them here.
Arbitrator: Where is here?
Petitioner: Here. In my back. On my back.
Arbitrator: The witness is indicating from where I'm sitting both shoulders and her upper back. Is that what you're seeing, gentlemen?
Mr. Carlson: Yes
Mr. German: Yes.

Petitioner testified that the trays weighed 20 to 30 pounds. (Arb. Tr. 26). Petitioner testified to pain in her upper and low back, neck, and left shoulder with numbness into both legs. *Id.* Petitioner presented to Concentra on June 11, 2010 giving a history of back pain symptoms while working. (Resp. Ex. 1). Petitioner was treated conservatively for a lumbar strain and was placed at full duty. On June 25, 2010 Petitioner was placed at MMI by Dr. Paloyan. Petitioner continued to work full duty without any lost time.

Petitioner went to Dr. Bialowas and Midwest Medicorp for physical therapy. (Resp. Ex. 2). An MRI of the lumbar spine dated August 5, 2010, revealed disk desiccation at L5-S1 with slight facet arthropathy at the L5-S1 without any evidence of disk herniation, spinal stenosis, or impingement. *Id* Petitioner began chiropractic

treatment with La Clinica *Id.* While she was given a 10 pound working restriction, she continued to do her regular work. (Arb. Tr. 28-29). An MRI of the thoracic spine dated July 12, 2011 revealed mid thoracic degenerative disk disease without herniated disks, spinal stenosis, or other abnormalities. (Resp. Ex. 2). Petitioner underwent an FCE through WorkWell on August 9, 2011. (Resp. Ex. 5). The FCE found that Petitioner's performance was inconsistent. *Id.* Petitioner demonstrated improved range of motion in her upper extremities during functional testing in comparison to formal range of motion testing. *Id.* Petitioner demonstrated improved lower extremity strength and endurance during functional tasks compared to formal testing. *Id.* During the exam, Petitioner refused to attempt greater than fifteen pounds for front carry despite no medical indications to stop the testing. *Id.* Petitioner exhibited a slow pace with multiple gait abnormalities and refused to crouch to complete a task. *Id.* The FCE report concluded that Petitioner's claimed functional limitations were not consistent with physical impairments or diagnosis and that her perceived abilities were below those objectively identified in the FCE. The FCE evaluator was unable to assess a return to work due to physical problems other than the referred diagnosis of lumbar, thoracic and cervical pain as well as due to the self-limited performance by Petitioner.

Respondent submitted surveillance of Petitioner. (Resp. Ex. 7). On July 5, 2010, Petitioner was seen sweeping, watering plants, bending, squatting, pushing a grocery cart containing grocery bags, as well as lifting and carrying the bags,

Dr. Michael Kornblatt performed an IME on Petitioner on December 5, 2011. (Resp. Ex 2). He noted a past history significant for periodic chronic episodes of back pain dating back to 2005. *Id.* Dr. Kornblatt opined that Petitioner suffered a work-related lumbosacral strain. *Id.* His examination of Petitioner was consistent with deconditioned state and a psychogenic component to pain complaints. *Id.* Dr. Kornblatt opined that Petitioner reached maximum medical improvement three months post-injury and did not need thoracic or lumbar spine surgery. Dr. Kornblatt opined that Petitioner could initially return to work with a 20 pound lifting restriction and then without restrictions over the next four to six weeks. *Id.* The final diagnoses were chronic dysfunction myofascial pain and degenerative disk disease that were unrelated to the alleged work accident. *Id.*

On February 11, 2013, Dr. Kornblatt performed a record review and drafted an addendum. (Resp. Ex. 3). Dr. Kornblatt reviewed the results of the FCE conducted on August 9, 2011 and opined that it was invalid. *Id.* Dr. Kornblatt ultimately concluded that his opinions remain as stated in his December 5, 2011 IME report. *Id.* As stated in that report, Petitioner sustained a lumbosacral strain as a result of the alleged work accident and reached MMI/full duty without restrictions by September 4, 2010. *Id.*

Petitioner continued to work her regular job until she was terminated on May 26, 2011. (Arb Tr. 50) Petitioner testified that she would have and could have continued in her regular job duties had she not been terminated. (Arb Tr. 50)

ACCIDENT AND CAUSATION

The Arbitrator finds that Petitioner sustained a temporary exacerbation of a degenerative back condition as indicated by the Concentra records, FCE, MRI and Dr. Kornblatt. Petitioner continued to work full duty without lost time and would have continued to do so, by her own testimony, if her job had not ended. The medical history records support a pre-existing degenerative back condition dating back to 2005. Petitioner testified that she had treated for back pain with Dr. Bialowas before her first claimed accident of March 7, 2008. Medical records from St. Anthony's Hospital report that Petitioner had complained of back pain in 2007 that was not attributed to any particular event. The 2010 and 2011 MRIs revealed spine degenerative changes

without any evidence of disk injuries. The FCE in August of 2011 was inconsistent, invalid and self-limiting with perceived limitations beyond the objective medical findings.

The Arbitrator is persuaded by Dr. Kornblatt's opinion that Petitioner's diagnoses of chronic pain dysfunction-myofascial pain syndrome and lumbar and thoracic disk disease are unrelated to the alleged work accidents. The Arbitrator finds that the temporary exacerbation and back strain ended by June 25, 2010 and that Petitioner returned to her baseline state and was full duty and MMI from any work injury as of June 25, 2010. Any medical treatment and complaints of symptoms after June 25, 2010 are not related to any of the alleged work accidents.

NATURE AND EXTENT

March 7, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of March 19, 2008 and finds that there was no permanency from this accident.

September 12, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of two weeks and finds that there was no permanency from this accident.

January 24, 2009

The Arbitrator finds that Petitioner sustained a finger strain with no lost time. Petitioner was at MMI within two weeks. Petitioner testified that she feels some numbness in her finger when she extends it. Based upon the foregoing, the Arbitrator awards 5% loss of use of the left index finger.

June 4, 2010

The Arbitrator finds that Petitioner sustained a slight exacerbation back strain with no lost time. The Arbitrator finds that Petitioner was full duty as of June 11, 2010 and MMI as of June 25, 2010. Based upon the foregoing, the Arbitrator awards 2% of the person as a whole.

TTD AND MEDICAL

Based upon the previous findings no TTD is awarded and no medical bills are awarded.

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

Dolores Mendoza,
Petitioner,
vs.

NO: 11WC 000215
18IWCC0282

Kelloggs's Company,
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 permanent partial disability, temporary total disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 6, 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 $3,300.00. 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: MAY 4 - 2018
o050118
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, DOLORES
Employee/Petitioner

KELLOGG'S COMPANY
Employer/Respondent

Case# **11WC000215**

09WC008671
09WC008672
10WC023866
10WC023867
09WC008670

18IWCC0282

On 10/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
ART GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
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

DOLORES MENDOZA
Employee/Petitioner

v.

KELLOGG'S COMPANY
Employer/Respondent

Case # **11WC215**

Consolidated cases:
09 WC 8671, 09 WC 8672
10WC23866, 10WC23867, 09 WC 8670

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 **March 21, 2016 and July 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 4, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$27,976.00**; the average weekly wage was **$538.00**.

On the date of accident, Petitioner was **57** years of age, **married**, with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$322.80**/week for **10** weeks, because the injuries sustained caused the **2%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

The Arbitrator does not award any medical bills per the attached memorandum of decision incorporated herein.

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

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

Signature of Arbitrator

October 6, 2016
Date

ICArbDec p. 2

OCT 6 - 2016

FACTS

Case #10 WC 23866 and Case #10 WC 23867

Petitioner voluntarily dismissed these two cases at the commencement of the hearing.

Prior Back Problems

Petitioner has a history of back pain and treatment dating back to 2005. (Resp. Ex. 1) Petitioner was diagnosed with and received treatment for thoracic and lumbar conditions in 2005. During cross-examination Petitioner initially denied any prior treatment for back pain but then admitted that she treated with Dr. Bialowas, her primary care physician, for back pain before 2008. (Arb. Tr. at 42).

On August 7, 2007, Petitioner presented to St. Anthony's Hospital with complaints of back pain that radiated and worsened with certain movements of her left shoulder. (Resp. Ex. 4). Petitioner reported at that time that she had been feeling left sided back pain for two months prior and did not indicate a specific incident that caused the pain. *Id.*

March 7, 2008 Accident

Petitioner was working for Respondent when she alleges an injury to her lower back on March 7, 2008. Petitioner testified that she was lifting trays weighing approximately 20 pounds. (Arb. Tr. at 18). Petitioner was treated at Concentra and was diagnosed with a lumbosacral strain. (Resp. Ex. 1). Petitioner underwent physical therapy until her release from care on March 19, 2008. *Id.* Petitioner had no lost time and continued to work her regular duties after her March 7, 2008 accident. (Arb. Tr. at 19).

September 12, 2008 Accident

Petitioner testified that she injured her low back again on September 12, 2008 as she was lifting trays of candy. Petitioner was transported to St. Anthony's Hospital where she was diagnosed with back pain (Pet. Ex.18). She continued to treat with her primary care physician, Dr. Bialowas. (Arb. Tr. 21). Petitioner presented to Concentra on February 3, 2009 with complaints about her back. (Resp. Ex. 1). Petitioner testified that she injured her back as she was lifting a tray that had candy stuck on the bottom. *Id.* Petitioner sustained no lost time and continued to work her regular duties after her September 12, 2008 accident. (Arb. Tr. at 22).

January 24, 2009 Accident

Petitioner alleges that she was lifting trays of sweets to empty at a machine and a coworker pulled a tray away from her which resulted in Petitioner's left index finger being bent. (Arb. Tr. 46). X-rays performed on January 31, 2009 were negative for fracture. (Pet. Ex. 16). Petitioner was seen by Dr. Bialowa, who prescribed her physical therapy and light duty. (Resp. Ex. 1). Petitioner presented to Concentra on February 3, 2009. *Id.* At Concentra she was diagnosed with a finger sprain and released her from care on February 3, 2009. *Id.* Petitioner continued to work her regular duties after her January 24, 2009 accident. *Id.*

June 4, 2010 Accident

Petitioner alleges a fourth accident took place on June 4, 2010. Petitioner's testimony on direct examination regarding this particular alleged accident was as follows:

Mr. German: Now, could you describe to the Judge how you injured yourself on that date?
Petitioner: On that day, they had me emptying out the sweet on two different bands when there are usually two persons for that, and they had me do it by myself. When I finished with the sweets, the pallets contained 22 trays, and you have to empty them in each band in less than a half an hour. When I was not able to keep up, then I would place them here.
Arbitrator: Where is here?
Petitioner: Here. In my back. On my back.
Arbitrator: The witness is indicating from where I'm sitting both shoulders and her upper back. Is that what you're seeing, gentlemen?
Mr. Carlson: Yes
Mr. German: Yes.

Petitioner testified that the trays weighed 20 to 30 pounds. (Arb. Tr. 26). Petitioner testified to pain in her upper and low back, neck, and left shoulder with numbness into both legs. *Id.* Petitioner presented to Concentra on June 11, 2010 giving a history of back pain symptoms while working. (Resp. Ex. 1). Petitioner was treated conservatively for a lumbar strain and was placed at full duty. On June 25, 2010 Petitioner was placed at MMI by Dr. Paloyan. Petitioner continued to work full duty without any lost time.

Petitioner went to Dr. Bialowas and Midwest Medicorp for physical therapy. (Resp. Ex. 2). An MRI of the lumbar spine dated August 5, 2010, revealed disk desiccation at L5-S1 with slight facet arthropathy at the L5-S1 without any evidence of disk herniation, spinal stenosis, or impingement. *Id* Petitioner began chiropractic treatment with La Clinica *Id.* While she was given a 10 pound working restriction, she continued to do her regular work. (Arb. Tr. 28-29). An MRI of the thoracic spine dated July 12, 2011 revealed mid thoracic degenerative disk disease without herniated disks, spinal stenosis, or other abnormalities. (Resp. Ex. 2). Petitioner underwent an FCE through WorkWell on August 9, 2011. (Resp. Ex. 5). The FCE found that Petitioner's performance was inconsistent. *Id.* Petitioner demonstrated improved range of motion in her upper extremities during functional testing in comparison to formal range of motion testing. *Id.* Petitioner demonstrated improved lower extremity strength and endurance during functional tasks compared to formal testing. *Id.* During the exam, Petitioner refused to attempt greater than fifteen pounds for front carry despite no medical indications to stop the testing. *Id.* Petitioner exhibited a slow pace with multiple gait abnormalities and refused to crouch to complete a task. *Id.* The FCE report concluded that Petitioner's claimed functional limitations were not consistent with physical impairments or diagnosis and that her perceived abilities were below those objectively identified in the FCE. The FCE evaluator was unable to assess a return to work due to physical problems other than the referred diagnosis of lumbar, thoracic and cervical pain as well as due to the self-limited performance by Petitioner.

Respondent submitted surveillance of Petitioner. (Resp. Ex. 7). On July 5, 2010, Petitioner was seen sweeping, watering plants, bending, squatting, pushing a grocery cart containing grocery bags, as well as lifting and carrying the bags,

Dr. Michael Kornblatt performed an IME on Petitioner on December 5, 2011. (Resp. Ex 2). He noted a past history significant for periodic chronic episodes of back pain dating back to 2005. *Id.* Dr. Kornblatt opined that Petitioner suffered a work-related lumbosacral strain. *Id.* His examination of Petitioner was consistent with deconditioned state and a psychogenic component to pain complaints. *Id.* Dr. Kornblatt opined that Petitioner reached maximum medical improvement three months post-injury and did not need thoracic or lumbar spine surgery. Dr. Kornblatt opined that Petitioner could initially return to work with a 20 pound lifting restriction and

then without restrictions over the next four to six weeks. *Id.* The final diagnoses were chronic dysfunction myofascial pain and degenerative disk disease that were unrelated to the alleged work accident. *Id.*

On February 11, 2013, Dr. Kornblatt performed a record review and drafted an addendum. (Resp. Ex. 3). Dr. Kornblatt reviewed the results of the FCE conducted on August 9, 2011 and opined that it was invalid. *Id.* Dr. Kornblatt ultimately concluded that his opinions remain as stated in his December 5, 2011 IME report. *Id.* As stated in that report, Petitioner sustained a lumbosacral strain as a result of the alleged work accident and reached MMI/full duty without restrictions by September 4, 2010. *Id.*

Petitioner continued to work her regular job until she was terminated on May 26, 2011. (Arb Tr. 50) Petitioner testified that she would have and could have continued in her regular job duties had she not been terminated. (Arb Tr. 50)

ACCIDENT AND CAUSATION

The Arbitrator finds that Petitioner sustained a temporary exacerbation of a degenerative back condition as indicated by the Concentra records, FCE, MRI and Dr. Kornblatt. Petitioner continued to work full duty without lost time and would have continued to do so, by her own testimony, if her job had not ended. The medical history records support a pre-existing degenerative back condition dating back to 2005. Petitioner testified that she had treated for back pain with Dr. Bialowas before her first claimed accident of March 7, 2008. Medical records from St. Anthony's Hospital report that Petitioner had complained of back pain in 2007 that was not attributed to any particular event. The 2010 and 2011 MRIs revealed spine degenerative changes without any evidence of disk injuries. The FCE in August of 2011 was inconsistent, invalid and self-limiting with perceived limitations beyond the objective medical findings.

The Arbitrator is persuaded by Dr. Kornblatt's opinion that Petitioner's diagnoses of chronic pain dysfunction-myofascial pain syndrome and lumbar and thoracic disk disease are unrelated to the alleged work accidents. The Arbitrator finds that the temporary exacerbation and back strain ended by June 25, 2010 and that Petitioner returned to her baseline state and was full duty and MMI from any work injury as of June 25, 2010. Any medical treatment and complaints of symptoms after June 25, 2010 are not related to any of the alleged work accidents.

NATURE AND EXTENT

March 7, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of March 19, 2008 and finds that there was no permanency from this accident.

September 12, 2008

The Arbitrator finds that Petitioner sustained a temporary exacerbation back strain with no lost time. Petitioner was never taken off work for this injury, and there are no medical records evidencing a permanent injury. The Arbitrator finds that Petitioner was full duty and MMI as of two weeks and finds that there was no permanency from this accident.

January 24, 2009

The Arbitrator finds that Petitioner sustained a finger strain with no lost time. Petitioner was at MMI within two weeks. Petitioner testified that she feels some numbness in her finger when she extends it. Based upon the foregoing, the Arbitrator awards 5% loss of use of the left index finger.

June 4, 2010

The Arbitrator finds that Petitioner sustained a slight exacerbation back strain with no lost time. The Arbitrator finds that Petitioner was full duty as of June 11, 2010 and MMI as of June 25, 2010. Based upon the foregoing, the Arbitrator awards 2% of the person as a whole.

TTD AND MEDICAL

Based upon the previous findings no TTD is awarded and no medical bills are awarded.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRENDA ROBINSON,

Petitioner,

vs. NO: 15 WC 15338

ADDUS HEALTHCARE, INC.,

18IWCC0283

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below but attaches the Decision of the Arbitrator, which is made a part hereof, for the statement of facts with the modifications noted below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission finds that Petitioner has proven that her current condition of ill-being is causally related to the motor vehicle collision she sustained while working on April 7, 2015. Petitioner credibly testified that prior to the motor vehicle accident, she did not have any problems with her neck. Following the accident, she suffered from bouts of dizziness, nausea and headaches. Petitioner sought care from an emergency room, chiropractor, and finally an orthopedic surgeon. Additionally, she underwent several radiographic diagnostic studies, which revealed an annular tear, herniation, and disc protrusion at C6-7. (Px7 – MRI study of 6/16/15)

The Arbitrator found Respondent's paid expert, Dr. Mirkin, to be more persuasive than Petitioner's treating physicians, and reasoned that Dr. Mirkin's opinions, combined with the fact Petitioner was able to return to work "on a full duty basis for some 13-14 months after her return to work for Respondent", was sufficient to deny Petitioner's claim. However, Petitioner has not really

returned to full-duty work. Prior to the accident, Petitioner was working 40-43 hours per week. (T. 43) After returning to work in August, 2015, and up to present day, Petitioner only works about 15 hours per week. (T. 43) Additionally, the objective studies show that Petitioner suffers from an annular tear at C6-7. Petitioner's symptoms have not improved with conservative treatment – PT and epidural steroid injections – and Petitioner remains symptomatic. The Commission finds Dr. Gornet's testimony regarding causation is more persuasive than that of Dr. Mirkin. Dr. Gornet opined that as a result of the trauma she sustained in the April 7, 2015, rear-end motor vehicle collision, she injured her disc C6-7. The Arbitrator erred in assigning greater weight to the opinions of Dr. Mirkin than to Dr. Gornet, and therefore the Commission reverses the Arbitrator and finds that the Petitioner's current condition of ill-being is causally related to her work-related motor vehicle accident of April 7, 2015.

As to the medical, the Commission finds that the medical expenses are awarded and that prospective medical treatment in the form of an orthopedic surgical consult to determine the appropriate necessary surgery, is awarded. Petitioner was not at maximum medical improvement (MMI) at the time she saw Dr. Mirkin on July 15, 2015. The additional treatment and imaging studies incurred after July 15, 2015 are awarded as they were reasonable and necessary. Petitioner was working reduced hours, and had not seen resolution of her symptoms from conservative treatment. Petitioner credibly testified that she did not have any of the problems with neck pain, dizziness, nausea or trouble looking down or reaching prior to the accident. She did not report any intervening accidents and completed conservative treatment with no relief. (T. 32-35) The June 16, 2015, MRI showed an annular tear. (Px7) This was later confirmed on a CT myelogram on November 3, 2015. (Px10) The objective testing reflects Petitioner's injuries were more significant than merely a cervical strain as Dr. Mirkin suggests. Dr. Gornet based his opinions that Petitioner was a surgical candidate on her clinical presentation along with peer reviewed studies that indicate the type of surgery proposed would alleviate her pain. (Px2 pp. 17-19) However, as Dr. Gornet had at different times recommended different surgeries and given the passage of time, the Commission finds that the prospective medical treatment awarded at this time is an orthopedic surgical consult to determine the appropriate treatment.

Finally, the Commission finds that Petitioner is awarded temporary total disability from April 28, 2015, through August 16, 2015, as Petitioner was not at MMI when she saw Dr. Mirkin on July 15, 2015. However, Dr. Mirkin opined that Petitioner could return to work. Petitioner returned back to work on August 17, 2015. Dr. Mirkin's report did not issue until August 7, 2015, and Petitioner did not receive TTD for the period from August 7, 2015, through August 16, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $253.00 per week for a period of 17 2/7 weeks, from April 28, 2015 through August 16, 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 or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $15,484.23 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

18IWCC0283

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded prospective medical care in the form of an orthopedic surgical consult to determine the appropriate treatment for Petitioner.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,958.00. 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: MAY 4 - 2018

Charles J. DeVriendt

CJD/dmm
o041018
049

Joshua D. Luskin

DISSENT

I respectfully dissent from the majority's decision and instead would affirm and adopt the findings of Arbitrator Melinda Rowe-Sullivan.

L. Elizabeth Coppoletti

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

ROBINSON, BRENDA
Employee/Petitioner

Case# **15WC015338**

ADDUS HEALTHCARE INC
Employer/Respondent

18IWCC0283

On 12/20/2016, 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 0.64% 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:

1459 LEVENHAGEN LAW FIRM PC
CHRISTOPHER T TUCKER
216 W POINTE DR SUITE B
SWANSEA, IL 62226

2795 HENNESSY & ROACH PC
DAVID A DOELLMAN
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

18IWCC0283

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Brenda Robinson
Employee/Petitioner

v.

Addus Healthcare, Inc.
Employer/Respondent

Case # 15 WC 15338

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 **Mt. Vernon**, on **October 6, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$18,545.28**; the average weekly wage was **$356.64**.

On the date of accident, Petitioner was **59** years of age, *married* with **0** dependent children.

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

Respondent shall be given a credit of **$4,048.00** 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 **$4,048.00.**

ORDER

Petitioner failed to prove that her current condition of ill-being is causally related to her accident of April 7, 2015. As a result thereof, Petitioner's request for prospective medical treatment as recommended by Dr. Gornet is denied.

Respondent shall pay for medical services **rendered up to and including July 15, 2015** 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 up to and including July 15, 2015** directly to the provider. Respondent shall pay any unpaid, related medical expenses **for treatment rendered up to and including July 15, 2015** 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 benefits paid through group insurance** under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$253.00**/week for **12 5/7** weeks, for the timeframe of **April 18, 2015 through July 15, 2015**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$4,048.00** for temporary total disability benefits already paid as stipulated by the parties at the time of arbitration.

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

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

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

Melinda M. Price Sullivan
Signature of Arbitrator

12/15/16
Date

ICArbDec19(b)

DEC 20 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Brenda Robinson
Employee/Petitioner

Case # **15** WC **15338**

v.

Consolidated cases: **N/A**

Addus Healthcare, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified at the time of arbitration that she is currently 60 years old and was employed by Respondent Addus Healthcare at the time of the incident on April 7, 2015. She testified she had been working for Respondent since May of 2003. She testified that at the time of the April 7, 2015 incident, she worked as a nursing assistant and provided care for at-home patients including sweeping, mopping, dusting, laundry and grocery shopping, and that she also took patients to and from their doctor's appointments. She testified that on April 7, 2015, she was sitting at a stop light in Mt. Vernon on 42nd Street and was rear-ended. She testified that at the time of the accident, she was transporting a patient to the doctor's office and then back home. She testified that they had just left the doctor's office and were at a stop light when she was rear- ended, and that the accident happened at about 1:50 in the afternoon.

Petitioner testified that her body on impact "went forwards and backwards" and that she had her seat belt on. She testified that she felt that the impact of the accident was "heavy". She testified she had no idea the truck was coming up behind her, and that she had no idea how fast the truck was moving behind her at the time. Petitioner testified that she did not lose consciousness as a result of the accident and was able to drive away from the scene by herself. She testified she took the client that she had in her car to Crossroads Hospital, but she herself did not seek treatment. She testified that she went to the hospital later that night for her own medical treatment.

Petitioner testified at the time of the collision, she had a headache. She testified that at the time of her initial emergency room treatment, she had developed neck pain, left-sided rib pain and pain in her left shoulder blade. She further testified that she was able to go back to work full duty the following day.

Petitioner testified she received treatment from Mary Piper, a nurse practitioner, at Salem Family Health. She testified that she continued to have pain in her neck and shoulder blades and received a corticosteroid injection. She testified that she then began receiving treatment from Dr. Bowman and had complaints of left chest, neck and shoulder blade pain. Petitioner then generally testified regarding her treatment with Dr. Bowman and stated she then saw Dr. Gornet in June of 2015, and that she underwent an MRI of her cervical spine. She testified that she then received two injections in her neck on July 2nd and July 16th as performed by Dr. Boutwell, but that the injections provided minimal relief. She testified that when she returned to Dr. Gornet, he recommended a disc replacement surgery to correct her neck pain. She testified that Dr. Gornet's recommendations for surgery remained consistent throughout her visits with him in 2016.

Petitioner admitted to having prior neck pain in 2011 after she fell at a client's home. She testified that she had complaints of left hip, left head, left shoulder and neck pain, but that after some initial treatment at Salem Township Hospital in January 2011, she did not receive any further treatment for her neck. She also testified that after the January 2011 incident and leading up to the April 7, 2015 motor vehicle collision, she had had no problems with her neck. She further denied any new accidents, injuries or issues with her neck following the April 7, 2015 accident.

Petitioner testified that she wants to proceed with surgery and was off work from April 18, 2015 to August 16, 2015. However, Petitioner further testified that Respondent last provided her with a temporary total disability check paying her through August 6, 2015.

On cross examination, Petitioner confirmed that she had a history of smoking as discussed with Dr. Mirkin during his exam. She testified that she quit in 2012 but had been smoking two packs a day for 30 years prior to that time. She confirmed she had been working for Respondent a little over a year (*i.e.*, 13-14 months) as of the time of the arbitration hearing since being released to go back to work.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The transcript of the deposition of Dr. Gornet was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Gornet testified that he is an orthopedic surgeon whose practice is devoted to spine surgery. (PX2).

Dr. Gornet testified that he first saw Petitioner on June 15, 2015, at which time her main complaint was neck pain to the base of her neck, headaches, both trapezius, both shoulders, upper back, pain between her shoulder blades and the left side of her chest. He testified that Petitioner reported that her problems began after an accident on April 7, 2015, when she was a belted driver who was struck from behind at low to moderate speed. He testified that Petitioner reported that initially she was so upset and stressed, and that her main concern was her client who also had chest pain. He testified that Petitioner did not recall any previous problems of significance with her neck or treatment, but that she did recall some issues in her low back which she thought were mild in approximately 2000. He testified that Petitioner had been off work since April 7, 2015 and that even sedentary work which required simple fixed-head positions or looking upwards significantly increased her neck pain and headaches. He testified that the physical exam results demonstrated that she had a mild decrease in biceps on the left at 4/5, but otherwise showed no focal deficit. He testified that x-rays of the cervical spine did not reveal any significant degeneration or disc pathology, and that she had some facet changes on the right at C4-5 and mild foraminal stenosis C4-5 right but none on the left. (PX2).

Dr. Gornet testified that he ordered a cervical MRI, which demonstrated an obvious annular tear and central herniation at C6-7 and a smaller protrusion at C5-6, and that he did not see any significant cord impingement or other abnormality but she did have some facet changes and foraminal stenosis on the right at C4-5. He testified that his impression was that Petitioner had a disc injury, for which he recommended steroid injections to relieve the discogenic pain. He testified that Petitioner had an injection at C6-7 on the right on July 2, 2015 and that she had another injection at C5-6 central on July 16, 2015. He testified that he believed that Petitioner injured her disc and disc mechanism at C6-7, that there was a strong possibility that she injured her disc at C5-6 and that she aggravated her pre-existing facet arthritis at C4-5. (PX2).

Dr. Gornet testified that he believed that Petitioner was temporarily and totally disabled during the period of time of June 15, 2015 through August 27, 2015, at which time he next saw her. He testified that at that time, Petitioner asked him to discuss with her the IME report of Dr. Mirkin dated July 15, 2015. He testified that he recommended that Petitioner continue with light duty and that she undergo a

CT myelogram. He testified that the CT myelogram was performed on November 2, 2015 and showed the central disc protrusion at C6-7 and mild facet arthritis. He testified that the majority of Petitioner's symptoms were axial neck pain and headaches at that time. He testified that as the CT myelogram did not show any significant arthritic changes in her facet joints at C6-7, he thought it was reasonable to do a disc replacement surgery at C6-7. (PX2).

Dr. Gornet testified that he next saw Petitioner on January 25, 2016, at which time he noted that the treatment for Petitioner at a minimum would be a disc replacement at C6-7 and potentially at C5-6. He testified that at the time of the next visit on April 25, 2016, he noted that Petitioner continued to have cervical pain, and that he continued to believe that she needed a disc replacement surgery at C5-6 and C6-7 causally connected to the motor vehicle accident of April 7, 2015. He testified that the treatment Petitioner had received for her neck including chiropractic care, physical therapy, epidural steroid injections and diagnostic testing, had been reasonable and necessary. (PX2).

On cross examination, Dr. Gornet testified that he reviewed Dr. Bowman's records as part of his assessment of Petitioner, as well as having reviewed the records from Mary Piper and Salem Hospital. He testified that the MRI films of June 15, 2015 were of good quality. He testified that he did not believe there was any compression on the spinal cord that he could see, nor was there any impingement on the spinal nerve roots. He agreed that Petitioner denied any kind of arm pain or weakness at the time of the initial examination. He agreed that his initial diagnosis was discogenic neck pain at C6-7 and potentially C5-6. (PX2).

On cross examination, Dr. Gornet agreed that Petitioner was a non-smoker at the time of his initial evaluation. He testified that the two injections that Petitioner received gave her temporary relief. He testified that there was nothing that changed in the course of Petitioner's treatment that led to the C5-6 disc replacement recommendation, and that it was more just consideration of the disc over the course of her care. (PX2).

The medical records of Salem Township Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on April 7, 2015 at 18:00, at which time it was noted that she was a driver that was rear-ended while sitting at a stop light, that she was restrained, that it happened in Mt. Vernon and that she had neck pain but no loss of consciousness. It was noted that Petitioner had a history of back pain, among other issues. It was noted that Petitioner's head was "jolted" back and forth. X-rays of the cervical spine performed on that date were interpreted as revealing (1) no acute fracture, dislocation, or bone lesion of the cervical spine; (2) mild spondylosis of cervical spine; (3) moderate osteoarthritis of the apophyseal joint of the right side of C4-C5. The diagnosis was that of neck pain – sprain/MVA. Petitioner was instructed to follow up in one week with Mary Piper, NP. (PX3).

The records of Salem Township Hospital reflect that Petitioner was seen on May 28, 2015 related to a therapy referral for neck and upper back pain with pain radiating to the left lateral chest. It was noted that Petitioner's left upper back was extremely sensitive to light touch. The Initial Evaluation dated May 28, 2015 noted that Petitioner complained of pain between the shoulder blades up to the neck, left side of the back and lateral side and left chest which she stated started after her car was rear-ended. It was noted that Petitioner was complaining of feeling dizzy/nauseated when she looked up or down, and that she also complained of increased pain with lifting, dressing, washing her hair or anytime she used her bilateral arms. The records reflect that Petitioner underwent treatment for the timeframe of May 28, 2015 through June 12, 2015. (PX3).

The medical records of Salem Family Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen by Mary Piper, NP, on April 16, 2015 for a recheck after MVA. It was noted that Petitioner was stopped at a stop light and was

rear-ended by a pick-up truck while she was in a Chevy Malibu. It was noted that Petitioner went to the emergency room later that night because her neck and shoulders were hurting, and that she was having pain to the shoulder blades and left chest with no shortness of breath. The assessment was that of costochondral chest pain and MVA restrained driver. Petitioner was instructed to take Tramadol if needed for pain and to undergo a chiropractic visit. At the time of the May 26, 2015 visit, it was noted that Petitioner was seen for a recheck of neck pain. It was noted that Petitioner was having persistent pain to the posterior neck with aches to the bilateral shoulders and upper back, and that her pain radiated to the left upper chest with any use of her arms at shoulder height or higher. It was noted that Petitioner had an appointment with Dr. Gornet scheduled for June 15, 2015. It was further noted that Petitioner was having intermittent headaches and dizziness, that she could not look up without dizziness and that she had pain to the left upper ribs with any pressure to the left lateral chest. The assessment was that of neck strain. Petitioner was instructed to continue physical therapy and to avoid lifting more than 10 pounds and overhead use of the arms. (PX4).

The medical records of Bowman Chiropractic were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on April 17, 2015 with a chief complaint of left chest, neck and shoulder blade pain. It was noted that Petitioner was rear-ended while in her car and that she was at a stop light. The diagnosis was noted to be that of cervical subluxation, cervical sprain/strain, cervicalgia, pain in thoracic spine, thoracic subluxation, sprain/strain of thoracic spine, myofascitis/myositis/myalgia and muscle spasms. Petitioner was given a work slip on that date, taking her off work until April 24, 2015. Petitioner was given a work slip on April 23, 2015, taking her off work until May 8, 2015. A work slip was issued on May 8, 2015 taking Petitioner off work until May 22, 2015. A work slip was issued on May 21, 2015, indicating that Petitioner was unable to work until June 16, 2015. Petitioner was also referred to Dr. Gornet on June 15, 2015. The records reflect that Petitioner underwent chiropractic treatment for the timeframe of April 17, 2015 through May 21, 2015. (PX5).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on August 29, 2016, at which time it was noted that "[again]" Dr. Gornet believed that Petitioner sustained disc injuries at C5-6 and to a greater extent at C6-7 as well as aggravation of some pre-existing arthritic changes at C3-4 and C4-5. It was noted that Dr. Gornet recommended disc replacement surgery at C5-6 and C6-7. It was noted that Petitioner continued to have predominantly neck pain and headaches with dizziness, and that the examination for the most part revealed 5/5 strength in all groups. A work slip was issued on that date, allowing Petitioner to work with light duty restrictions of no lifting greater than 10 pounds, must be able to alternate between sitting and standing as needed and no overhead work. (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 cervical spine on June 15, 2015, which was interpreted as revealing (1) C6-7 3.5mm central broad-based protrusion with a central annular tear; there is mild bilateral foraminal stenosis at this level but no central canal stenosis; (2) right foraminal protrusion with associated facet arthropathy at C3-4 resulting in mild to moderate right foraminal stenosis but no central canal stenosis; (3) central broad-based herniation at C5-6 resulting in dural displacement but no central canal or foraminal stenosis. (PX7).

The medical records of Pain & Rehabilitation Specialists of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent a right C6-C7 epidural steroid injection on July 2, 2015 for a pre- and post-operative diagnosis of cervical disc degeneration and displacement. Petitioner also underwent a C5-C6 epidural steroid injection (central) on July 16, 2015 for a pre- and post-operative diagnosis of cervicogenic headache. (PX8).

The medical records of Orthopedic Ambulatory Surgery Center of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records were effectively duplicative of those as contained in Petitioner's Exhibit 8. (PX9: PX8).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent a cervical myelogram on November 2, 2015 for neck pain with bilateral shoulder pain. The CT of the cervical spine post-myelogram was interpreted as revealing (1) C6/7 central broad based 2.5mm protrusion resulting in dural displacement but no central canal or foraminal stenosis; (2) circumferential disc bulge at C5/6 resulting in mild to moderate right greater than left foraminal stenosis but no central canal stenosis; (3) right-sided facet arthropathy at C3/4, C4/5 and C5/6. (PX10).

The transcript of the deposition of Dr. Mirkin was entered into evidence at the time of arbitration as Respondent's Exhibit A. Dr. Mirkin testified that he is an orthopedic surgeon with subspecialty training in spinal surgery. He testified that he performed an IME on July 15, 2015, at which time Petitioner reported that on April 7, 2015 she was driving a client in her personal car and was struck from behind. He testified that Petitioner told him that she developed pain in her neck and that when he saw her, she was not complaining of any pain in her back but she had that at one time. He testified that Petitioner reported that she had dizziness, headaches and neck stiffness and some chest wall pain on the left, and that the complaints she verbally reported were consistent with the pain diagram she completed. (RXA).

Dr. Mirkin testified that Petitioner's physical examination revealed that her cervical range of motion was limited by her large neck, that there was no spasm and that she complained of pain in her neck when he lightly touched her head or the back of her neck which were signs of symptom magnification or Waddell signs. He testified that Petitioner's deep tendon reflexes were intact in the biceps, triceps and brachioradialis, and that her motor and sensory exams were normal. He testified that x-rays of the neck revealed normal lordosis and very minimal degenerative changes, and that his review of an MRI of the cervical spine revealed some slight degenerative disc bulging at several levels but no compression of the spinal nerves or no compression of the spinal cord. He testified that Waddell signs can indicate some functional overlay of non-organic pain behaviors. He testified that the disc bulge at C6-7 was a very common finding, and that disc bulges only meant something if they were causing pressure on a nerve or spinal cord and caused primarily radicular symptoms. (RXA).

Dr. Mirkin testified that after performing the exam and reviewing the medical records, the diagnosis that he reached was that of a cervical strain from an automobile accident. He testified that the appropriate treatment for a cervical strain was a short course of physical therapy or chiropractic therapy, and that he did not feel that Petitioner needed any further treatment for the work injury when he saw her as she was doing functionally very well and she had no indication for anything invasive such as injections or surgery. He testified that Petitioner's physical exam, particularly her neurologic exam, was normal, she had no radicular symptoms and she had an MRI that did not reveal any significant abnormality other than a non-compressive disc bulge at C6-7. He testified that, regardless of causation and the work injury, if Petitioner presented to him just for treatment of her neck pain, he would not have recommended surgery. (RXA).

Dr. Mirkin testified that he did not feel that Petitioner needed work restrictions as related to the work injury when he saw her in July, which was several months after the date of the incident. He testified that he thought Petitioner had reached maximum medical improvement, that she had no objective signs of any significant disability and very minimal subjective signs, so he did not think she had any disability. (RXA).

Dr. Mirkin testified that he was later provided additional medical records from Dr. Gornet's office to review and that he prepared a report in conjunction with his review of those records, which was dated July 5, 2016. He testified that he noted that Dr. Gornet saw Petitioner multiple times and that other than the first visit, there was no indication that he ever examined Petitioner. He testified that his review of the additional materials did not change his original opinions from his first report. (RXA).

On cross examination, Dr. Mirkin agreed that the findings on the MRI and CT myelogram reports were abnormal. He testified that he has performed surgery on individuals who had had axial neck pain with compression of the spinal cord, but had never performed surgery on individuals who had mild neck or disc bulging with axial pain and without radicular pain. He agreed that it was fair to say that surgeons did not always agree on the same method of treatment for a patient's symptoms. He agreed that the conditions that were identified in the studies were conditions that were subject to further degeneration. (RXA).

On redirect, Dr. Mirkin testified that the findings on the MRI report of June 16, 2015 would be what he would consider abnormal based on the radiologist's impression as noted in the report. He agreed that he reviewed the MRI films himself, and that his impression was that at C6-7 there was a bulge, that it did not push away the spinal fluid and that there was no compression of the spinal cord. He testified that he thought they were both saying there was no pressure on the spinal cord or spinal nerve roots. (RXA).

The medical records of Salem Township Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit B. The records contained the physical therapy records as contained in Petitioner's Exhibit 3, as well as additional records pertaining to a CT of the abdomen/pelvis performed on December 26, 2012; a polysomnography study performed on August 29, 2013; and a polysomnography with CPAP/BiPAP Titration on October 11, 2013. The records also contained the emergency room records dated April 7, 2015 as contained in Petitioner's Exhibit 3. (RXB; PX3).

Also included within the records of Salem Township Hospital were those for a visit at Salem Family Health Center on March 26, 2015, at which time Petitioner was seen for issues with hypertension, among others. Petitioner was seen on January 26, 2011 after a fall down three wooden steps landing on the ground with her left side hitting the head and shoulder on the railing on the way down. It was noted that Petitioner was complaining of left hip, left head, left shoulder and neck pain, and that she was at work when it happened. X-rays of the left shoulder performed on January 26, 2011 were interpreted as revealing (1) no acute fracture or dislocation; (2) old healed traumatic bone change at the superior aspect of the greater tuberosity. A CT of the head was performed on the same date, which was interpreted as revealing (1) a small acute subcutaneous hematoma at the left temporal area without evidence of fracture of the skull; (2) no acute intracranial abnormality is identified. Petitioner was diagnosed with a left scalp contusion, a left shoulder and hip contusion and a minimal concussion. (RXB).

The records of Salem Township Hospital further reflect that Petitioner was sent for physical therapy for her left knee for a left knee sprain/contusion after an accident date of September 16, 2004 while tripping on a sidewalk carrying groceries for a client. Petitioner underwent physical therapy for the timeframe of September 28, 2004 through October 7, 2004. (RXB).

CONCLUSIONS OF LAW

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 work accident of April 7, 2015. The Arbitrator finds that the opinions of Dr. Mirkin as testified to during the course of his deposition, when considered in conjunction with the objective findings on the diagnostic films performed

and as coupled with Petitioner's own testimony regarding her ability to work on a full duty basis for some 13-14 months after her return to work for Respondent, cumulatively support the finding that Petitioner has failed to prove that her current condition of ill-being is related to the underlying accident in this case.

Having reviewed the medical records and deposition testimony of each physician in this matter, the Arbitrator finds Dr. Mirkin's opinions to be more persuasive than those proffered by Dr. Gornet. The Arbitrator notes that Petitioner testified that following the incident, she was able to immediately go back to work full duty and that she did so for approximately two weeks until she taken off work by her chiropractor, Dr. Bowman. (PX5). The Arbitrator notes that the medical records reflect that Petitioner denied any kind of radicular pain at the time of her initial treatment at Salem Township Hospital. (PX3; RXB). In addition, the Arbitrator notes that the medical records demonstrating Petitioner's treatment course throughout the pendency of her claim did not document any reports of radicular pain or issues with symptoms radiating into her upper extremities. (PX2; PX4; PX5; PX6; PX8; RXA). The Arbitrator places great significance of the testimony of Dr. Mirkin that, regardless of causation and the work injury, if Petitioner presented to him just for treatment of her neck pain, he would not have recommended surgery. (RXA). This, when coupled with Dr. Mirkin's findings of positive Waddell signs upon the performance of the physical examination on July 15, 2015, causes the Arbitrator to place greater reliance upon the opinions of Dr. Mirkin in this case, who opined that Petitioner sustained a cervical strain as a result of the automobile accident at issue.

The Arbitrator further notes that Dr. Gornet's diagnoses and recommendations for treatment appear to have changed throughout the course of his care despite the fact that the medical records demonstrate that Petitioner's reported symptomology had remained the same. The Arbitrator notes that Dr. Gornet at the time of the November 2, 2015 visit only recommended a single disc replacement at C6-7. At the time of the next visit on January 25, 2016, the records reflect that Dr. Gornet indicated that at a minimum he would recommend replacement at C6-7 and "potentially at C5-6". The records further reflect that at the time of the April 25, 2016 visit, Dr. Gornet indicated that he recommended disc replacement surgery at C5-6 and C6-7, despite the fact that no change in symptomatology was noted in the records. (PX2). Furthermore, the Arbitrator is admittedly very troubled by the fact that Dr. Gornet's records failed to document that he performed any physical examinations of Petitioner after the initial evaluation took place on June 15, 2015. (PX2).

That said, having considered the record in its entirety, the Arbitrator finds the opinions of Dr. Mirkin to be more persuasive and well-founded in the record, and thereby places greater weight on his opinions as compared to those of Dr. Gornet. As a result thereof, the Arbitrator finds Petitioner sustained a cervical sprain as a result of the accident of April 7, 2015, and that she had attained maximum medical improvement from such cervical strain as of the time of the IME with Dr. Mirkin on July 15, 2015. Accordingly, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being is causally related to the work accident of April 7, 2015.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment up through the date on which the IME was performed on July 15, 2015 with Dr. Mirkin was reasonable, necessary and causally related to the work accident of April 7, 2015. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 1, **for medical services rendered up to and including July 15, 2015,** 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 prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that her current condition of ill-being is causally

related to the accident of April 7, 2015, Petitioner's request for prospective medical treatment as recommended by Dr. Gornet is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner claims temporary total disability benefits for the timeframe of April 18, 2015 through August 16, 2015. (AX1).

In light of the Arbitrator's finding that Petitioner has failed to prove that her current condition of ill-being is causally related to the accident of April 7, 2015 and that Petitioner reached maximum medical improvement as of the time that she was evaluated by Dr. Mirkin on July 15, 2015, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the timeframe of April 18, 2015 through July 15, 2015. The Arbitrator further finds that Respondent is entitled to a credit in the amount of $4,048.00 for temporary total disability benefits already paid as agreed to by the parties at the time of arbitration. (AX1).

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

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Jaye Snyder n/k/a Sanstrom

Petitioner,

vs. No. 06 WC 24187

Mesaba Aviation,

Respondent.

18IWCC0284

DECISION AND OPINION ON REVIEW UNDER SECTIONS 8(a), 16, 16(a) 19(k) and 19(l)

Timely Petitions for Review under sections 8(a), 16, 16(a), 19(k) and 19(l) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of further medical benefits, penalties, and attorney's fees and being advised of the facts and law, grants the petitions for the reasons set forth below.

On April 4, 2014, the Arbitrator filed a decision awarding Petitioner past medical expenses, mileage and a permanency award of 40% of the person as a whole. Neither party appealed the Arbitrator's decision. On April 6, 2017 Petitioner filed a petition for penalties and attorney's fees asserting that Respondent had not, to date, paid all medical bills that had been awarded. Petitioner asks the Commission "to order respondent to pay for reasonable and necessary medical expenses incurred and further to award penalties in accordance with Section 19(l), 19(k) and Section 16 of the Illinois Workers' Compensation Act and for such other and further relief as is fair and just." Petitioner has not sustained any new accidents since her trial. Petitioner filed an 8(a) petition on April 6, 2017.

On December 6, 2017 hearing was conducted on Petitioner's motion pursuant to section 8(a) and penalties. By way of history, Petitioner sustained a work-related injury on May 15, 2006 when she was 21 years of age and working a college-job for Respondent. She sustained a large paracentral disc herniation at L4-5, central disc herniation at L5-S1, and anterolisthesis of L5 from L4. Petitioner subsequently underwent extensive, unsuccessful, conservative medical

18IWCC0284

therapy.

On May 17, 2007, Petitioner underwent a L4-5 bilateral laminotomy, L4-5 transforaminal interbody fusion surgery with bone graft in the disc spaces, pedicle screw and posterior rods placement performed by Dr. Harms. Petitioner's post-operative care included a back brace, nerve medication, narcotic pain medication, physical therapy, epidural steroidal injections and significant restrictions. She was referred to Christie Clinic for chronic pain management. Petitioner continued to experience low back and dysesthetic left leg pain.

In the years that have followed the work injury Petitioner has been under continual medical care that has failed to relieve Petitioner's back and leg pain. She has been diagnosed with failed back syndrome. A spinal cord stimulator was placed on July 6, 2010 by Dr. Dold and was beneficial in reducing Petitioner's chronic pain. Petitioner, however continues to require Hydrocodone, Lyrica, Zanaflex and Wellbutrin periodically to manage breakthough pain.

In March 2011 Petitioner became pregnant with her first child. Petitioner immediately stopped taking prescription narcotic pain medications. Petitioner's obstetrician approved chiropractic treatment as an acceptable form of pain management. Petitioner continued to use chiropractic management for pain control during the time she was nursing her baby daughter and throughout her second pregnancy. Petitioner has continued chiropractic treatment with Dr. Hemmer on recommendation of Dr. King, her pain management specialist, to help manage her pain while minimizing reliance on prescription pain medications which impair her ability to continue working and raise her family.

On April 4, 2014 Petitioner was awarded benefits, including but not limited to, past medical expenses, mileage and a permanency award of 40% loss of the person as a whole. Petitioner has not suffered any new accidents since the arbitration hearing on January 28, 2014.

Petitioner testified at hearing before Commissioner Mathis that Respondent timely paid the permanent partial disability award but delayed paying certain medical bills, out of pocket expenses, and mileage expenses. Petitioner received a check for $ 7,297.43 on approximately November 12, 2016. A second check was received on November 11, 2017 in the amount of $4,125.00. No explanation was given for the delay. In Respondent's brief the delay is vaguely attributed to "missed communications". Respondent stipulated that the balance of the award was not paid until November 12, 2016 and November 11, 2017.

Petitioner testified that since the trial she has continued to receive treatment for her injuries from Dr. King at Christie Clinic and chiropractic care from Dr. Hemmer at Tuscola Pain & Wellness Center. Dr. King testified that Petitioner benefits from chiropractic care in that it gives her symptomatic relief and reduces the need for narcotic pain medications. Both Dr. King and Dr. Hemmer testified that Petitioner's current pain and need for treatment are related to her 2006 work injury.

Petitioner has encountered recurring difficulties getting prescription pain medication paid for by Respondent. Her pharmacy expenses are not reliably covered by workers' compensation and Petitioner must sometimes pay her bills out of pocket or submit her bills

through her group health insurance resulting in Petitioner being responsible for partial payment.

Dr. King testified that Petitioner's spinal cord stimulator has required battery replacement since June 2016. On June 1, 2017 the battery had still not been replaced and as a result the spinal cord stimulator was not operational. Petitioner testified that the repeated requests made to Respondent for battery replacement have been neither approved or denied placing the requests in a prolonged state of "limbo".

Dr. King testified that following Petitioner's fusion surgery her sacroiliac joints had to take up additional motion segment stress. Petitioner has chronic unremitting pain that is never going to go away. Chiropractic care assists Petitioner in managing that pain. Dr. King recommends some injection therapy to reduce Petitioner's pain and improve her mobility. Dr. King testified that Petitioner also has tronchanteric bursitis which is a result of fusion surgery.

Respondent retained Dr. Van Fleet to perform a section 12 evaluation on Petitioner. This examination was conducted on December 23, 2016. Dr. Van Fleet diagnosed failed back syndrome but opined that complaints of pain other than the operable level were unrelated to the work accident. He further opined that chiropractic treatment was unnecessary and that the future treatment recommended by Dr. King would not be beneficial.

Respondent correctly states in its brief that Petitioner has worked full time and not lost any salary or pay since the arbitration hearing. Respondent asserts that under the Act it is only obligated to provide that treatment that is necessary to cure and relieve the effect of the work injury and that the treatment Petitioner is receiving is doing neither. Respondent speculates without any supporting evidence that the respective courses of treatment ordered by Dr. King and Dr. Hemmer may be adversely affecting one another to the Petitioner's detriment. If that were the case an opinion to the effect would have been expected from Dr. Van Fleet.

The Commission adopts the opinions of Dr. King and Dr. Hemmer concerning Petitioner's ongoing need for pain management and concomitant chiropractic therapy. Petitioner sustained a significant work injury at a young age. Much of Petitioner's future care will likely be palliative rather than curative. Respondent argues that the treatment records reveal no plan to help Petitioner "other than the same course(s) of treatment that, to date has not provided relief." Unfortunately, Petitioner sustained a life altering work injury at a young age and will continue to experience pain that will wax and wane for the rest of her life. Respondent's argument that the care is not reasonable and necessary because Petitioner continues to need it does not hold water.

The Commission finds that the delay in paying Petitioner's medical bills following the arbitration hearing was unreasonable and Respondent offered no explanation for the delay in their brief.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's medical bills totaling $11,924.59 as reflected in Petitioner's Exhibits 3,4,13 and 14 pursuant to the Medical fee Schedule as provided in Sections 8(a) and 8.2 of the Act.

18IWCC0284

IT IS FURTHER ORDERED BY THE COMMISSION THAT Respondent shall pay Petitioner for the prescription medication bills paid out of pocket by Petitioner or paid on her behalf as reflected in Petitioner's Exhibits 5, 6, 15 and 16 totaling $2,654.92.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for any and all reasonable and necessary prospective care and treatment recommended by Dr. Hemmer and Dr. King, including but not limited to, chiropractic treatment, nerve ablation procedures, sacroiliac injections, prescription medications, and expenses associated with the replacement of the Medtronic battery in Petitioner's spinal cord stimulator.

IT IS FURTHER ORDERED BY THE COMMISSION THAT Respondent shall pay Section 19(k) penalties in the amount of 50% of the sum of the unpaid medical expenses, reduced pursuant to the fee schedule or negotiated rate. Respondent shall pay Section 16 attorney's fees of 20% of the sum of unpaid medical expenses reduced pursuant to the fee schedule or negotiated rate.

IT IS FURTHER ORDERED BY THE COMMISSION THAT Respondent shall pay Petitioner penalties pursuant to Section 19(l) in the amount of $10,000.00.

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. 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.

Stephen J. Mathis

DATED: MAY 4 – 2018
o-3-8-18
SM/msb
44

Stephen Mathis

David L. Gore

Deborah L. Simpson

Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEGAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Hultquist,
Petitioner,
vs.

NO: 13WC 16324

18IWCC0285

E.D. Etnyre,
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, causal connection, medical, temporary total disability, 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 January 30, 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.

MAY 7 - 2018

DATED:
o042518
LEC/jrc
043

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HULTQUIST, RICHARD
Employee/Petitioner

Case# **13WC016324**

E D ETNYRE
Employer/Respondent

18IWCC0285

On 1/30/2017, 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:

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

0163 CLARK JUSTEN ZUCCHI FROST ETAL
JEFFREY ZUCCHI
7320 N ALPINE RD
ROCKFORD, IL 61101

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

Richard Hultquist
Employee/Petitioner

Case # **13** WC **16324**

v.

18IWCC0285

E. D. Etnyre
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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **December 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 1, 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 alleged accident *was* given to Respondent.

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

In the year preceding the alleged injury, Petitioner earned **$42,099.20**; the average weekly wage was **$809.60**.

On the date of accident alleged, Petitioner was **58** 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 is entitled to a credit of **$9,792.83** for nonoccupational disability benefits under Section 8(j) of the Act.

ORDER

Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

January 27, 2017
Date

JAN 30 2017

FACTS:

On February 1, 2013, the Petitioner was employed by the Respondent and had been so employed for 34 years. The Petitioner testified that he worked 55 hours a week, and that he was constantly using his hands. The Petitioner testified that during his first 2-3 years of his employment with the Respondent he worked in metal fabrication, and he then worked as a welder for approximately 27 years. The Petitioner testified that during the last 4-5 years of his employment with the Respondent, he worked as a welder and an assembler. The Petitioner testified that during those last 4-5 years, he actually welded for approximately 2-3 hours a day and that he did assembly work the rest of the time. The Petitioner testified that he worked 55 hours a week, and was constantly using his hands in the performance of his job duties.

The Petitioner described that his job as a welder involved welding inside of large tanks and welding frames into a jig for 10 hours at a time. The Petitioner testified that he frequently welded overhead or in difficult positions and that he would often switch hands. He described that when his right hand began to get numb and weak, he would switch to the left hand. The Petitioner testified that he also did assembly work which he described as putting a hopper and frame together with torque wrenches, power drills, and impact wrenches. The Petitioner indicated that he would also switch the hand he would use to hold the tools he used while performing the assembly duties.

Richard Kruger, one of the Respondent's supervisors, testified he has worked for the Respondent for 42 years and that the Petitioner had worked in his department for a few years, beginning around 2008. Mr. Kruger testified that the Petitioner's job duties included welding and the assembly of hoppers. Mr. Kruger testified that the Petitioner actually welded for only 15-20 minutes a day from 2008 – 2013 and that he performed prep work and assembly work the rest of his shifts. Mr. Krueger testified that the assembly job did not require any twisting or torqueing of either extremity and that the Petitioner would actually use the impact wrench for only about 30 minutes per day. Mr. Krueger testified that, when he used the impact wrench, the Petitioner would hold one nut in place with a wrench and then use the impact wrench to tighten or loosen another nut. According to Mr. Krueger, an employee would typically hold the impact wrench with the non-dominant hand and hold the other wrench with the dominant hand.

The Petitioner testified that approximately 10 years prior to February of 2013 he began to notice that his hands would go numb while he was driving. The Petitioner testified that his symptoms worsened as time went on and that he also experienced numbness in his hands at work. The medical records demonstrate that in July of 2009 the Petitioner sought treatment at the Sterling Rock Falls Clinic for complaints of pain and swelling in his left hand "that has been going on for some time now" as well as complaints of pain in his elbows and knees. In a consultation report dated July 28, 2009, Dr. Raheem Nazeer noted that his impression was "probable rheumatoid arthritis". The records also demonstrate that the Petitioner was seen at KSB Hospital in July of 2011 for a medication review. Under the heading of "Social History" it is noted that the Petitioner "works as a welder" and "reports having carpal tunnel symptoms with numbness and tingling in his fingers bilaterally". The assessment at that time included rheumatoid arthritis and probable carpal tunnel syndrome. On November 27, 2012 the Petitioner was noted to complain of pain in his hands and arms and the assessment again included possible carpal tunnel syndrome.

On February 6, 2013 the Petitioner sought treatment with Dr. Anatoly Rozman at Rockford Medical Rehabilitation. Dr. Rozman noted that the Petitioner was "suffering from rheumatoid arthritis significantly" and had complaints of pain in all of his joints. Dr. Rozman also noted that there were "also signs of significant carpal tunnel syndrome with positive Phelen's test and decreased sensation in the distribution of the median nerve." Dr. Rozman's assessment on that date was "Lumbar thoracic sprain – moderate" and he recommended referral to a rheumatologist and an EMG. The Arbitrator notes that there is nothing in the record of that visit relating to the Petitioner's job or work activities and there is nothing indicating that the Petitioner related his condition to his job or any specific work activity.

On February 20, 2013 Dr. Rozman performed the EMG and reported that it demonstrated severe bilateral carpal tunnel syndrome and at least moderate left ulnar nerve entrapment. Dr. Rozman recommended that the Petitioner consult with an "orthopedic surgeon and neurosurgeon for possible cervical release". In his progress note of that date, Dr. Rozman noted the EMG which revealed carpal tunnel syndrome and he prescribed Norco, Neurontin, and braces for the Petitioner. Dr. Rozman also noted that the Petitioner was "looking to open workmen's compensation case" and that, due to the severity of the carpal tunnel syndrome, the Petitioner would require an "Orthopedic surgery/.Neurosurgery consult.

The Petitioner testified that after he received the recommendation for a surgical consultation, he informed his foreman, Rich Kruger, that he was going to miss time from work to undergo surgery on his hands. On cross-examination the Petitioner indicated that he reported his need for surgery to his foreman on February 1, 2013. Both the Petitioner and Rich Krueger testified that the Petitioner told Rich Krueger only that he was going to require surgery on his hands and that the Petitioner did not relate his carpal tunnel syndrome or the need for surgery to his work activities at that time. Rich Kruger testified that the Petitioner had never complained to him about his hands prior to that time and that the Petitioner never related his hand condition to his work activities.

On March 20, 2013, Dr. Rozman noted that the Petitioner was "filing for Workmen's compensation" and that the Petitioner continued to work but had "increasing pain in the wrist". Dr. Rozman also indicated that further delay in approval for his claim and proceeding with compressive rehabilitation would be detrimental for the Petitioner. On April 17, 2013, Dr. Rozman noted that the Petitioner reported "that his work does not accept Workmen's Compensation claims for carpal tunnel syndrome" and Dr. Rozman indicated that he did not see what the problem was as the Petitioner's "existing condition is clearly related to the patient's work activities." The Arbitrator notes that there is nothing in the record of these visits which specifically mentions or describes the Petitioner's work activities.

On May 22, 2013 the Petitioner saw Dr. Rozman and reported increasing pain in both of his hands and an inability to do his work as a welder. Dr. Rozman's diagnosis was exacerbation of carpal tunnel syndrome and he prescribed the Petitioner off work for two weeks. Dr. Rozman also directed the Petitioner to consult with an orthopedic surgeon as soon as possible and he ordered occupational therapy.

On May 29, 2013, the Petitioner was seen by Dr. Thomas Hernandez with complaints of bilateral hand pain and numbness. Dr. Hernandez noted that the Petitioner had a many year history of bilateral hand pain and numbness and an EMG which showed positive severe bilateral carpal

tunnel syndrome and moderate cubital tunnel syndrome on the left. Dr. Hernandez' assessment was bilateral severe carpal tunnel syndrome, right worse than left, and left moderate cubital tunnel syndrome and he recommended surgery for the Petitioner. Dr. Hernandez also noted that given to the severity of Petitioner's symptoms and the fact that he already had thenar atrophy, the result of the carpal tunnel release would be much less predictable than a typical patient with mild or moderate disease.

On June 6, 2013 the Petitioner underwent surgery on his right wrist by Dr. Hernandez. On June 19, 2013 Dr. Hernandez noted that the Petitioner was doing very well, with his numbness "mostly completely improved", and was very happy with the results. On July 3, 2013 Dr. Hernandez noted that the Petitioner "has done very well with his right side" and was anxious to proceed with the left side. On July 24, 2013 Dr. Rozman noted that the Petitioner had an "excellent result" with the right carpal tunnel release..

On July 30, 2013 the Petitioner underwent surgery on the left wrist. On August 14, 2013, Dr. Hernandez noted that the Petitioner was doing well with his numbness "essentially completely resolved. Dr. Hernandez noted that the Petitioner could continue activities as tolerated but could not yet return to full duty at work, given the fact that he had a very labor-intensive job involving his hands.

On September 4, 2013, Dr. Rozman noted that the Petitioner's strength was improving but that he still had complaints of significant pain. On September 11, 2013, Dr. Hernandez noted that the Petitioner's symptoms were significantly improved after the surgeries with only some occasional numbness bilaterally and some persistent pain, mainly in his forearm up toward his elbow. Dr. Hernandez cleared the Petitioner to return to full duty at work, although he indicated that the Petitioner might require some adjustments.

The Petitioner testified that he did not return to work after the surgeries and that the surgeries did not provide him with any lasting relief. On October 23, 2013, the Petitioner returned to Dr. Rozman with complaints of pain and numbness in both of his hands and numbness and tingling in the area of the median nerve distribution. Dr. Rozman indicated that the Petitioner was unable to return to work at that time. On October 28, 2013, the Petitioner resigned from his employment with the Respondent. The Petitioner testified that he has not worked since the initial surgery on June 6, 2013, that he did receive Short Term Disability benefits from Respondent through October 9, 2013, and that he is now receiving social security disability benefits.

At the request of the Respondent, the Petitioner was seen by Dr. Stephen Weiss on November 4, 2013. Both Dr. Weiss' report and evidence deposition were admitted into evidence. The history provided to Dr. Weiss by the Petitioner was that he had been a welder for 40 years and that he worked 10 hour days, 5 days a week plus 5 hours on Saturday welding. He further indicated that the work was about evenly split between both hands. The Petitioner also indicated that during the last five years of his employment with the Respondent that he only welded about four hours a day but that he also did assembly work using hammers and drills, also split evenly between his right and left hands. Dr. Weiss testified that rheumatoid arthritis is a common cause of carpal tunnel syndrome and he opined that unless the Petitioner was performing repetitive, forceful gripping as a welder with both hands, then the work activities were not an aggravating factor. Dr. Weiss opined that if the Petitioner was indeed performing repetitive, forceful gripping as a welder, with both hands, then the work activities probably were a contributing factor.

The Petitioner continued treatment with Dr. Rozman following his examination by Dr. Weiss. On January 22, 2014, he reported 40-50% improvement since surgery but he continued to describe numbness and tingling in both hands. Dr. Rozman performed repeat nerve conduction testing on October 15, 2014 which evidenced moderate carpal tunnel syndrome on both sides. On April 1, 2015, Dr. Rozman indicated that the Petitioner was complaint with his home exercise program, but was not able to return to work.

The Petitioner testified that he has continued to receive physical therapy for his hands and that it has helped him to move his hands a little better. He testified that he currently continues to have difficulty with gripping things, and he has numbness in his hands and fingers as well as a loss of sensation in his fingertips. The Petitioner testified that he has not been able to return to welding as he lacks sufficient grip strength in his hands.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (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 and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all the elements of his claim by a preponderance of the credible evidence. Tee Arbitrator finds that the Petitioner failed to meet that burden here.

While the Arbitrator notes that the Petitioner worked for the Respondent for 34 years as a welder and an assembler, there is conflicting evidence as to the Petitioner's actual job duties and the extent to which his job activities involved any repetitive forceful squeezing, gripping or grasping or significant vibratory impact. Similarly, there was conflicting evidence as to how much the Petitioner used both hands in the performance of his job activities. The Petitioner's testimony as to how much welding he did and how much he used an air impact wrench as well as how he actually performed those activities was contradicted by the testimony of the Respondent's witness, Rich Krueger. The job activities noted by Dr. Weiss were also different than the job activities testified to by the Petitioner and Rich Krueger, who was the Petitioner's supervisor. The Petitioner acknowledged that he would weld, at most, 1 to 2 hours per day while Rich Krueger testified that the Petitioner actually welded significantly less than one hour per day. There was no testimony by any witness that the Petitioner welded for four hours a day and did assembly work with a hammer and drills another five hours per day.

More significantly, however, there is nothing in the medical records which indicates that the Petitioner's treating physicians had any understanding of the Petitioner's actual job activities. While Dr. Rozman opined in one of his office notes that the Petitioner's condition was clearly related to his work activities, there is no mention of the Petitioner's actual job duties or activities contained anywhere in Dr. Rozman's records. Similarly, while Dr. Hernandez noted that he was awaiting

treatment approval from Workers' Compensation; his records contain no mention of the Petitioner's actual job activities and contain no specific causation opinion.

There is little credible evidence in the record from which to conclude that the Petitioner's work activities involved any significant forceful gripping, grasping, or vibratory impact, and there is no specific or persuasive medical opinion in the record from which to conclude that the Petitioner's work activities were injurious or causative of his condition of ill-being. Additionally, the record demonstrates that the Petitioner had been previously diagnosed with rheumatoid arthritis which Dr. Weiss testified can cause carpal tunnel syndrome.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent. The Arbitrator further finds that the Petitioner failed to prove that his condition of ill-being is causally related to his work activities for the Respondent. The Petitioner's claim for compensation is, therefore, denied.

In light of the Arbitrator's findings relating to the issues of accident and causation, determination of the remaining disputed issues is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul Schenfeld,
Petitioner,
vs.

NO: 13WC 23837

18IWCC0286

City of Chicago,
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 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 April 5, 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: MAY 7 - 2018

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

d042518
LEC/jrc
043

18IWCC0286

Dissenting Opinion

I must respectfully dissent on the issue of permanent partial disability. Based on the Appellate Court's reasoning in *Will County Forest Preserve v. IWCC*, 970 N.E.2d 16 (3rd Dist. 2012), I would find that Petitioner should be compensated with a person-as-a-whole award under §8(d)2 of the Act instead of a left leg award under §8(e)12. Although *Will County* addressed the proper classification of a shoulder injury, I believe the same principles are applicable here regarding the hip.

Petitioner was initially diagnosed with trochanteric bursitis at MercyWorks on June 26, 2013. On July 11th, Dr. Cordes at Northshore Orthopaedics recorded a history of the work accident and that Petitioner felt an acute onset of pain in the left hip, primarily over the anterior superior iliac spine. On examination, Petitioner was nontender over the greater trochanter (femur) but was tender over the anterior superior iliac crest. His diagnosis was "most likely a hip flexor strain." I would find that the iliac crest is part of the pelvis, not the leg.

On August 1st, Dr. Cordes noted pain in Petitioner's left back and buttock area. At Petitioner's physical therapy evaluation on August 19th, his pain was located in the left oblique, left anterior-lateral hip, and left gluteus. The assessment indicated that Petitioner's subjective and objective findings were consistent with left hip pain but that he also exhibited left oblique and piriformis pain.

I would also find that the back and buttock are not part of the leg, that the oblique muscle is in the abdomen, and although the piriformis muscle attaches to the greater trochanter of the femur, it originates in the sacrum, a part of the spine.

Based on the above, I would award 5% of the person-as-a-whole under §8(d)2 of the Act.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHENFELD, PAUL
Employee/Petitioner

Case# **13WC023837**

CITY OF CHICAGO
Employer/Respondent

18IWCC0286

On 4/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0010 CITY OF CHICAGO
HOLLY ANDERSON
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Paul Schenfeld
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13** WC **23837**

Consolidated cases: **N/A**

18IWCC0286

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 **Chicago**, on **March 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 **June 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 as explained *infra*.

In the year preceding the injury, Petitioner earned **$90,039.56**; the average weekly wage was **$1,731.53**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of **$12,368.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$12,368.68**.

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 as reflected in Petitioner's Exhibit 6 for the medical bill of Northshore University Specialists in the amount of $148.00 that remains unpaid as provided in Sections 8(a) and 8.2 of the Act pursuant to the medical fee schedule.

Permanent Partial Disability: Schedule Injury

As explained in the Arbitration Decision Addendum, Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 15.05 weeks, because the injuries sustained caused the 7% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

April 4, 2017
Date

APR 5 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Paul Schenfeld
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13** WC **23837**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include whether there is a causal connection between Petitioner's current condition of ill-being and accident at work, Respondent's liability for payment of a medical bill, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Paul Schenfeld (Petitioner) testified that he began working for the City of Chicago Office of Emergency Management and Communications (Respondent) as a Lineman. Petitioner is affiliated with IBEW Local 9.

Petitioner testified that his job duties were to install and maintain security cameras as well as the cables used by 911 and fire departments. He explained that his job requires a lot of climbing, going up and down ladders, getting on and off of trucks, working on platforms, splicing cables, and installing cameras above ground "in the air" or repairing cables below ground in a manhole. Petitioner testified that the cables with which he works range from a "six-pair" cable that is 1-1½ inches in diameter to a "200-pair" cable that is 4 inches in diameter. The cables are anywhere from feather to heavy weights and arrive at the job sites via cable carts measuring 8-12 feet tall depending on the size of the cable reel. Under normal circumstances, the cable automatically unwinds when pulling it off of the cart, but Petitioner explained that if there was little room it had to be removed by hand.

Accident

The circumstances of Petitioner's accident are not in dispute. AX1. On June 24, 2013, Petitioner testified that he was working at DePaul University assigned to hang "25-pair" cable all in one length. Petitioner testified that there was a cable cart, but the worksite required him to remove the cable manually otherwise they would have to close down traffic on Fullerton Avenue. As Petitioner was pulling the cable, he explained that he felt something hit him on left side. Petitioner described the sensation like a "lightning bolt" and explained that he could not move on left side. He was unable to move and felt a sharp pain in his lower back. He had never felt anything like this before and believed he may have pulled something in his left hip, which was very tender to the touch. Petitioner also testified that he felt a "heatwave" in the left buttock.

Petitioner testified that another employee helped him to a wall. He explained that he did not know what happened, but had to stand still for several minutes to regain his composure. Petitioner testified that he had

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

never injured his low back or left hip, or previously received medical care for either body part. He continued working that day, but did minimal activity. Petitioner did not go work the following day.

Medical Treatment

The medical records reflect that Petitioner went to MercyWorks on June 26, 2013, Petitioner went to MercyWorks. PX1 at 26. The physician noted that Petitioner experienced pain when moving his leg under his own power, but had no radiculopathy or back pain. *Id.* He was diagnosed with trochanteric bursitis. *Id.* Petitioner returned to MercyWorks on July 3, 2013. PX1 at 24. On physical examination, Petitioner had mild tenderness to palpation over the left greater trochanter and was diagnosed with trochanteric bursitis. *Id.* In the interim, on July 1, 2013, Petitioner saw his primary care physician who referred him to an orthopedic surgeon. PX2 at 28.

Petitioner then saw Scott Cordes, M.D. (Dr. Cordes) on July 11, 2013. PX2 at 15-21, 29. Dr. Cordes noted Petitioner's acute onset of pain while at work in the left hip while pulling a cable primarily over the anterior superior iliac spine. *Id.* Dr. Cordes placed Petitioner off of work and ordered physical therapy. *Id.*

On August 1, 2013, Petitioner returned to Dr. Cordes who noted that physical therapy had not yet been authorized. PX2 at 12-14, 30. Petitioner reported some pain in the left back and buttock area and that he was doing his own rehabilitation by swimming, stretching, and biking. *Id.* Petitioner testified that his low back and buttock symptoms were not improving at this point. Dr. Cordes reiterated his order for physical therapy. *Id.*

Petitioner did undergo the recommended physical therapy at AthletiCo from August 19, 2013 through September 6, 2013. PX3. Petitioner testified that the physical therapy helped him quite a bit.

In the interim, Petitioner returned to Dr. Cordes on August 29, 2013. PX2 at 8-10, 31. Dr. Cordes noted Petitioner's report that physical therapy had helped him significantly. *Id.* Dr. Cordes diagnosed Petitioner with a strain of the left hip flexor and released him back to work effective September 9, 2013. *Id.*

Independent Medical Evaluation – Dr. Coe

On January 18, 2014, Petitioner submitted to a medical evaluation with Jeffrey Coe, M.D. (Dr. Coe) at his attorney's request. PX4. Dr. Coe took a history from Petitioner, performed a physical examination, reviewed various treating medical records, and rendered opinions regarding the relatedness, if any, of Petitioner's medical conditions to his accident at work. *Id.* At the time of his evaluation, Dr. Coe noted Petitioner's report "of pain in the outer border of his left hip. He stated that the pain was made worse by climbing (ladders or into trucks) and by cold exposure. He complained of slight stiffness at his left hip. He complained of numbness and tingling in the lateral left thigh region." *Id.*

On physical examination, Dr. Coe noted that Petitioner had tenderness over the left hip greater trochanteric bursa as well as trigger points in the left paralumbar and gluteal musculature. *Id.* He also noted weakness of the left hip with lateral hip pain and decreased sensation of the lateral left thigh consistent with an unrelated diagnosis of meralgia paresthetica. *Id.* He diagnosed Petitioner with left greater trochanteric bursitis. *Id.* He opined that Petitioner's injury at work caused permanent partial disability to the left leg and that there was a causal connection between Petitioner's left hip strain and injury at work. *Id.* Dr. Coe indicated that Petitioner

was in need of ongoing treatment for the now chronic condition. *Id.* Dr. Coe also opined that appropriate treatment would include orthopedic follow up and a trial of left greater trochanteric bursal steroid injections. *Id.*

In an addendum letter dated April 29, 2014, Dr. Coe noted his review of additional treatment records and reiterated his findings with a continued recommendation for injections. PX5.

Additional Information

Petitioner testified that while Dr. Coe recommended steroid injections, he did not undergo that treatment. He was released full duty after physical therapy was completed. Petitioner acknowledged that part of his physical therapy involved performing cable pulls and ladder climbs, which are part of his work duties. Petitioner testified that he returned to his regular job as a Lineman, but he felt aggravation to the left hip, back and thigh conditions while at work. He explained that he had to take Aleve twice a day and Advil four times a day because of his symptoms in the left hip, buttocks and left lower back area. He testified that climbing, twisting, turning, opening manhole covers, and his regular work duties aggravate his condition. Petitioner testified that he continues to experiences numbness and tingling in his left thigh up to his hip, which he never experienced before his accident at work.

Petitioner also testified that that he was involved in a car accident in 2014 and another accident at work in March of 2016, but these incidents did not involve his low back, hip or thigh.

ISSUES AND CONCLUSIONS

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

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's claimed current condition of ill-being is related to the injury sustained on June 24, 2013. In so finding, the Arbitrator again notes the consistency of Petitioner's testimony with the medical records submitted into evidence. At MercyWorks, Petitioner was diagnosed with trochanteric bursitis. Those medical records reflect Petitioner's onset of symptoms after his accident at work. Petitioner then sought treatment with Dr. Cordes, who ordered physical therapy and ultimately diagnosed Petitioner with a strain of the left hip flexor. At his attorney's request, Petitioner also saw Dr. Coe for a medical evaluation. Dr. Coe causally related Petitioner's condition with the injury at work. Petitioner was not required to undergo an evaluation by any physician at Respondent's request, and the information contained in Petitioner's treatment records and Dr. Coe's reports are uncontroverted. Indeed, Petitioner's testimony regarding his condition after his accident at work during medical treatment and through the date of hearing is uncontroverted. Given the consistency of Petitioner's testimony with the other evidence submitted at the hearing, the Arbitrator also finds Petitioner's testimony to be credible. Based on all of the foregoing, the Arbitrator finds that Petitioner has established a continued causal connection between his current condition of ill-being and accident at work.

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:

Petitioner claims entitlement to payment of a medical bill from Northshore University Specialists in the amount of $148.00 for services rendered after his accident at work. After consideration of the record as a whole, the Arbitrator finds that the treatment rendered to Petitioner is reflective of reasonable and necessary medical treatment to alleviate him of the effects of the injury he sustained at work. Therefore, the Arbitrator awards payment of the Northshore University Specialists medical bill in the amount of $148.00 contained in Petitioner's Exhibit 6 as it is for reasonable and necessary medical treatment related to his accident at work.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of the injury, the Arbitrator finds 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 the hearing, 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 no permanent partial disability impairment report was offered into evidence. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Lineman at the time of his accident and that he was released back to full duty by Dr. Cordes. This evidence is uncontroverted. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 58 years old at the time of the accident. This fact is stipulated by the parties. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that there was no evidence of any diminishment in Petitioner's future earnings capacity as a result of his accident. Thus, the Arbitrator 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 sustained an injury to the left hip resulting in symptoms in the left hip, upper thigh, and buttock as well as minimally in the paralumbar region. Petitioner provided unrebutted testimony about ongoing symptoms requiring daily use of over-the-counter pain medications to relieve these symptoms. Petitioner also testified about an ongoing sensation of "aggravation" of his left hip, thigh and buttock symptoms when performing his job duties after his return to work. Petitioner's testimony and Dr. Coe's opinion regarding the causal connection between Petitioner's injury at work and left hip strain is uncontroverted. No contrary opinion by any physician was offered into evidence. 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 7% loss of use of the left leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Dripps,
Petitioner,

18IWCC0287

vs.

NO: 11 WC 43077

Super Mix (alleged lending employer) and
Rock Solid Stabilization (alleged Borrowing employer),
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondents herein and notice given to all parties, the Commission, after considering the issues of permanent disability, nature and extent, vocational rehabilitation, maintenance, borrowing/lending employer 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 27, 2017, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay $868.36/week for life, commencing April 27, 2017, as provided in Section 8(e)18 of the Act, because the injury caused permanent and total disability. Commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

18IWCC0287

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

DATED: MAY 7 - 2018
o4/19/18
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 19(b) ARBITRATOR DECISION

18IWCC0287

DRIPPS, DAVID
Employee/Petitioner

Case# **11WC043077**

SUPER MIX (ALLEGED LENDING EMPLOYER) AND ROCK SOLID STABILIZATION (ALLEGED BORROWING EMPLOYER)
Employer/Respondent

On 6/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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.

0247 HANNIGAN & BOTHA LTD
KEVIN S BOTHA
505 E HAWLEY ST SUITE 200
MUNDELEIN, IL 60060

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL R EGAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

2965 KEEFE CAMPBELL & ASSOCIATES
JOHN P CAMPBELL
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

18IWCC0287

18IWCC0287

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

David Dripps
Employee/Petitioner

v.

Super Mix (alleged lending employer) and Rock Solid Stabilization (alleged borrowing employer)
Employer/Respondent

Case # 11 WC 43077

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **April 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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 [x] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Borrowing/Lending and Whether Petitioner is Permanently and Totally Disabled.**

FINDINGS

On the date of accident, **September 28, 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. **Respondent Super Mix is the lending employer and Respondent Rock Solid Stabilization is the borrowing employer.**

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 **$67,707.64**; the average weekly wage was **$1,302.47**.

On the date of accident, Petitioner was **42** years of age, ***single*** 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 **$242,309.85** for TTD, and for maintenance, and **$0.00** for other benefits, for a total credit of **$242,309.85**.

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 **$868.36**/week, for **140-4/7** weeks, commencing **9/29/2011** through **2/11/2013** and **8/20/2014** through **12/14/2015** pursuant to §8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$868.36**/week, for **150-4/7** weeks, commencing **2/12/2013** through **8/19/2014** and **12/15/2015** through **4/27/2017** pursuant to §8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$7,707.26** to **Lake Forest Hospital**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any payment made for this medical expense.

Respondent shall pay Petitioner permanent and total disability benefits of **$868.36**/week for life, commencing **4/27/2017**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after 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

6/26/17
Date

JUN 27 2017

18IWCC0287

STATEMENT OF FACTS:

Petitioner, David Dripps, testified that on September 28, 2011 he was employed by Respondent Super Mix as a Truck Driver. Petitioner had been a Truck Driver for the previous 16 years and began to work for Respondent Super Mix in June, 2011.

Petitioner testified that in August, 2011, he was offered by the Supervisor in Spring Grove, Illinois, to go up to North Dakota to work. Petitioner was to haul concrete cement in a bulker tanker up to the jobsite. Petitioner began this job in August, 2011. (Respondent Super Mix Ex. 5) Petitioner testified that the Super Mix dispatcher, Tommy, asked Petitioner to go to North Dakota with another Super Mix employee. This other employee was also a Driver. Petitioner testified that in North Dakota there were no Super Mix supervisors present. This job in North Dakota, according to Petitioner, was with Jonathan Pease of Rock Solid. Petitioner indicated that in addition to the trucks driven by himself and the other driver, there was a third Super Mix truck at the site, which he thought was driven by a Rock Solid employee.

Petitioner testified that he would receive his day-to-day dispatch orders from a Rock Solid employee -- a Rock Solid driver at the motel in the evening time. Petitioner testified that Tommy at Super Mix did not provide him his orders indicating "Tommy didn't know what was going on out there." Petitioner testified that he would drive to South Dakota to pick up concrete powder. Petitioner testified that he followed the same Rock Solid guys that he followed from Illinois.

Petitioner testified that at the jobsite, he would take his orders from Rock Solid drivers, laborers or occasionally Jonathan Pease himself. At the time of the accident he was driving a Super Mix truck, he was paid by Super Mix and Super Mix covered his expenses of the hotel. Petitioner never received any compensation from Rock Solid.

Jack Pease (hereinafter referred to as "Jack") testified in this matter via deposition. (Super Mix RX 6) He is the owner of Super Mix, Inc. (Super Mix RX 6, p. 6) Jack testified that Petitioner drove a semi-bulker trailer for him. (Super Mix RX 6, p. 7) Jack's son, Jonathan Pease (hereinafter referred to as "Jonathan") owned co-Respondent Rock Solid Stabilization. (Super Mix RX 6, p. 7) Jack testified he was familiar with the company, Rachel Contracting; Jack thought Rachel Contracting at one time was Jonathan's largest customer. (Super Mix RX 6, p. 8)

Jack testified that in the Summer, 2011 he became aware of a project in North Dakota for roadwork by Rachel Contracting. (Super Mix RX 6, pp. 8-9) Jonathan called him and said he was doing a job for Rachel, and that Rachel and Rock Solid needed help. There were not enough bulkers in North Dakota to service the project they were doing. (Super Mix RX 6, p. 9) Jack testified that he glanced at a map to see if it was feasible to take one load per day and that the cartage rate was appropriate. (Super Mix RX 6, p. 10) Jack testified that he then agreed to send at least two trucks to help them out and he instructed his dispatcher to find two drivers willing to go to North Dakota and make the arrangements with Jonathan and Rachel on what they are supposed to do. (Super Mix RX 6, p. 10) Jack testified that there was no written contract between his company and Rachel Contracting. (Super Mix RX 6, p. 10) Jack also denied that there was any written documentation regarding this project between Super Mix and Rock Solid. (Super Mix RX 6, p. 13) Jack denied that Super Mix had any employees in North Dakota that he had any control over there, knowing what was going on other than they needed help hauling to a jobsite from a cement terminal. (Super Mix RX 6, p. 11) Jack testified he had a limited amount of control over Petitioner while Petitioner was in North Dakota. Jack stated that he imagined that someone from the site, either Rock Solid or Rachel, told Petitioner where to dump, what time to show up,

and to keep hauling until they didn't need them anymore. (Super Mix RX 6, p. 12)

Jonathan testified both by evidence deposition and in person. (Rock Solid RX 6, T. p. 89, et. seq.) Jonathan testified that he was the sole owner of Rock Solid Stabilization. (Rock Solid RX.6 p.4) Jonathan testified that he never paid Petitioner for any work while on the job and saw him approximately for a half hour per day on the job, once a day. (Rock Solid RX6 T.8-9) Jonathan testified that somebody with his company would tell Petitioner where to park and where to get him to next. Petitioner did not drive any of his trucks. (Rock Solid RX.6 p.10). There was no fee agreement between his company and his dad's company and no written or verbal agreement. (Rock Solid RX.6 p.14-15) He testified that the drivers would be on the job site for 30-45 minutes or 1 hour maximum if there was an issue. (Rock Solid RX.6 p.18) Jonathan agreed he made the initial contact with Jack to arrange for Super Mix to be present in North Dakota. (Rock Solid RX 6, p. 28) Jonathan agreed Petitioner performed work activities similar to the work his drivers were doing. (Rock Solid RX 6, p. 28) The truck that Petitioner drove was very similar, not exact, but the same function as trucks that Jonathan had on the job. (Rock Solid RX 6, p. 27)

Petitioner testified that at the jobsite, he would hook his truck up to a Rock Solid blower; he was told to follow a particular truck at the hotel by a Rock Solid driver. Petitioner testified his truck did not have a blower. He would pull up and wait for a Rock Solid truck that he was told to be behind on his dispatch so he could use the Rock Solid truck to blow off his load in the trailer. Petitioner testified he had to use a Rock Solid truck to blow the load off. Petitioner received his instructions from a Rock Solid employee.

Jonathan verified Petitioner's version of how his truck would be unloaded at the jobsite indicating, "...our truck would be on the site and the subcontractor would blow the product into our truck . . ." (Rock Solid RX 6, p. 29)

Jonathan testified that he was not privy to any contract between Super Mix and Rachel Contracting. (Rock Solid RX 6, p. 31) The contract in evidence (Super Mix RX 3) reveals that Rock Solid's contract with Rachel reflects how much Super Mix would be paid. Also, the contract labeled "standard short form agreement" lists Rachel as the general contractor and Rock Solid as the subcontractor. He testified to a clause in the contract that any subcontractor shall not assign any of the work without prior written approval of Rachel and that he would not be able to hire any other individuals through his company without written consent from Rachel. He further testified denying ever having a written contract with Super Mix and the contract was not signed by anyone from Super Mix. The contract does not mention any other broker other than Super Mix and Rock Solid. (Super Mix RX 3)

Additionally, Rock Solid provided Super Mix with a certificate of insurance, listing Super Mix as a certificate holder, and verifying that Rock Solid had workers' compensation coverage for the period in question. (Super Mix RX 4)

On the accident date, Petitioner was driving down the road when his truck caught a gust of wind. His truck went alongside and hit a semi going the opposite way. Petitioner provided that he ended up in a ditch and injured his left foot. The accident was reported to the dispatcher Tommy at Super Mix through his brother.

Medical documentation submitted show that on September 28, 2011, while en-route to Rapid City, SD, Petitioner lost control of his tractor trailer and ended up in a ditch. He was brought to Southwest Healthcare Service by Bowman Ambulance. (PX.1 p.5) The records indicate that he was driving a semi and the wind caused him to lose control of the vehicle and he ran off the road. He was treated for pain and noted to have a gross open comminuted fracture of the left talus with dislocation with additional fractures of the tarsus. He was placed in a splint and transferred to Rapid City Regional Hospital via ground ambulance. (PX.1 p.2-3) He was admitted to the Rapid City Regional Hospital with multiple comminuted fracture fragments of the talus

underneath the tibia. He also had a Type II lateral Hawkins 3 talar neck fracture and underwent irrigation and debridement, reduction of the talus and placement of a wound VAC. (PX.2 p.2-5)

Upon his return to Illinois, Petitioner followed with Dr. Anand Vora at Illinois Bone & Joint Institute on October 10, 2011 who ordered an updated CT scan. Thereafter, Petitioner underwent additional surgery on October 27, 2011 at Lake Forest Hospital. Dr. Vora performed 1.) left talar open reduction and internal fixation; 2.) posterior tibial tendon synovectomy, debridement with retinacular repair and reduction; 3.) open reduction and external fixation of the left cuboid bone; 4.) left open reduction and external fixation of the third metatarsal fracture; and 4.) left lateral wound debridement deep to muscle. The postoperative diagnosis was 1.) left talus fracture; 2.) third metatarsal fracture; 3.) left cuboid crush fracture (nutcracker injury); 4.) posterior tibial tendon dislocation; and 5.) left lateral food open wound. (PX.2 p.10-12)

Petitioner continued to follow-up with Dr. Vora and remained off work. He underwent additional surgery on December 8, 2011. On this date Dr. Vora performed a removal of the external fixator, loose and infected and tract and frame of the left ankle. He also performed irrigation and debridement to deep fascia of left lower extremity lateral wound and applied a short leg cast. (PX.2 p.20-21)

On December 21, 2011, Dr. Vora referred Petitioner to Dr. Leonard Lu, a plastic surgeon for potential skin graft. (PX.2 p.22-24) On January 18, 2012, Dr. Leonard Lu performed a split thickness skin graft to the left non-healing ankle wound. (PX.2 p.27-28)

On May 5, 2012, Dr. Vora removed the hardware of the left foot and performed a realignment triple arthrodesis, a naviculocuneiform arthrodesis with calcaneal bone graft and a separate incision autograft. Dr. Vora also performed a posterior tibial tendon debridement, synovectomy and tendo-Achilles triple cut lengthening. (PX.2 p.37-40) By May 23, 2012, Dr. Vora referred Petitioner to Lake Forest Hospital due to an infection in the left foot. (PX.2 p.43) There he was provided antibiotic medication. (PX.2 p.45-47) He was also advised to follow-up with Dr. Daniel Zimmerman in infectious disease specialist.

On February 11, 2013, Petitioner followed up with Dr. Vora. The doctor noted diffuse swelling in the entire left lower extremity from the knee down with pitting edema. Dr. Vora suggested he return to a sedentary job only, walking 1 to 2 hours a day with a weight restriction of 30 lbs. only when walking. He should be restricted to office flat surfaces only and no uneven surfaces. The doctor provided he could not drive anything that uses the left lower extremity such as a clutch. He could drive using the right extremity only. Dr. Vora did not believe he could return to work as a truck driver. Dr. Vora provided the restrictions were permanent restrictions and opined that Petitioner had reached maximum medical improvement. He was to follow-up with his primary care physician, Dr. Kim for narcotic pain medication. (PX.2 p.63-64)

Petitioner then entered a vocational rehabilitation program recommended by MedVoc Rehabilitation. Petitioner testified that during 2013, he saw his primary care physician, Dr. James Kim who prescribed blood pressure pills, Xanax and Norco and continued to see Dr. Zimmerman. (PX.4)

Due to ongoing pain in the left ankle, Petitioner followed up with Dr. Vora on August 20, 2014. A physical exam revealed he had complete lateral foot overload and significant hindfoot varus which was quite traumatic compared to the contralateral side. X-rays showed varus deformity and malalignment. Dr. Vora's impression was left hindfoot arthrodesis with severe crush injury and chronic pain. Dr. Vora recommended realignment triple arthrodesis with lateralizing calcaneal osteotomy and a transverse tarsal osteotomy to correct the foot to plantigrade position and noted that the surgery was directly related to the original injury, subsequent treatment and related to the severe nature of the injury with original bone loss. (PX.2 p.66-67)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. George Holmes on October 1, 2014. A physical examination of his left foot revealed little, if any dorsiflexion and plantar flexion with no inversion or eversion of the hindfoot. Dr. Holmes' diagnosis was a varus hindfoot deformity with forefoot adduction deformity with some malalignment issues regarding the tibia on the left side when compared to the right. Dr. Holmes opined that the condition was causally related. He felt Petitioner was unable to return to work as a truck driver and was restricted to sedentary work. He recommended a trial period of immobilization in a cast or an AFO brace and failing that, realignment of the foot and thereafter he might be a candidate for a fusion from the tibia through the talus and into the calcaneus. (PX.6)

Dr. Vora heeded Dr. Holmes opinion and attempted bracing first. (PX.2 p.68) Petitioner failed bracing and conservative management and as a result, Dr. Vora performed a left transverse tarsal derotation, osteotomy revision, triple arthrodesis realignment of the left foot and ankle. The hardware was also removed. Dr. Vora also performed a lateralizing Dwyer calcaneal osteotomy, a Tendo-Achilles triple-cut lengthening and peroneus longus to brevis tenodesis. The postoperative diagnosis was left foot painful retained hardware, left hindfoot varus deformity, left transverse tarsal deformity with rigid varus malunion, peroneal contracture and equinus contracture of the ankle. (PX.2 p.72-74)

Petitioner continued to consult Dr. Vora and on December 14, 2015 was placed at maximum medical improvement. At that time, Dr. Vora opined that the fractures had healed and his ankle would be a limiting factor. Dr. Vora opined that Petitioner was at a very high risk for ankle arthritis and opined that he would almost certainly require additional surgery in the future. Dr. Vora released him to return to work with restrictions of no lifting or carrying more than 40 pounds, no climbing of ladders or stairs, limit standing and/or walking to less than 30 minutes per hour, to use an ankle brace and cane as needed, no ladders, no heights, no uneven surfaces and flat surfaces only. (PX.2 p.96-97)

Petitioner testified he completed the ninth grade in high school and was in special education classes. He was diagnosed with ADD in high school and was prescribed Ritalin. As an adult, he is currently prescribed Adderall for this condition. Petitioner testified that currently, he could only walk about a block (about 10-20 minutes) before his foot swells up and hurts. At the time of trial, he testified that he had throbbing pain in the left foot. He described it as a sharp pain on the lateral side of the ankle where the surgery took place. He testified that he could only stand 15-20 minutes at a time and uses a cane 99% of the time. He is ankle swells up constantly. His current medications include Norco and Xanax which are prescribed by Dr. Kim.

At the request of Respondent Super Mix, Petitioner he met with Julie Bose from MedVoc Rehabilitation (Hereafter, MedVoc). The plan was to enroll him in a job search program and enroll in GED classes at the community college. He participated in GED preparatory classes for 8 weeks but did not take the GED exam because he did not pass the class.

Petitioner testified that in the beginning of July 2014 he went to a Doubletree Hotel with Kathleen Doehla to complete an application for employment for a shuttle driver position. He subsequently returned for an interview; however, was not offered a job because he required a DOT physical card and the job exceeded his restrictions. There were also allegations that Petitioner did not dress appropriately for the interview and that his fly was undone. Thereafter, Petitioner's benefits were suspended.

Petitioner testified that due to ongoing pain in his left foot and ankle, he resumed treatment with Dr. Vora on August 20, 2014 wherein additional surgery was recommended. Petitioner was also taken off work at this time.

Petitioner testified that he was released to return to work with permanent restrictions of no lifting more than 40 pounds, no ladder or stair climbing, standing and walking less than 10 minutes per hour, to wear an

ankle brace as needed, use a cane as needed and not to work at any heights or on any uneven surfaces by Dr. Vora on December 14, 2015. This prompted him to begin looking for alternative work for which he kept a record of his job searches. Petitioner introduced into evidence the job searches from January 4, 2016 through March 1, 2016 which marked and received as Petitioner's Exhibit 8. Petitioner testified that in addition to the jobs listed in Petitioner's Exhibit 8, he also performed job searches on the Internet via his phone through Indeed.com which were not listed in the exhibit. Petitioner indicated that he did not look for work for the period of December 14, 2015 through January 24, 2016 as he was awaiting a response from Respondent Super Mix regarding accommodation of his restrictions. Petitioner indicated he did not receive any compensation until March 8, 2016.

Petitioner resumed vocational rehabilitation with MedVoc on March 8, 2016. Petitioner testified that he never returned to complete the GED classes because they were too difficult for him and he needed a tutor. He testified that when appearing for job interviews he wore T-shirts of the Polo variety with a collar and 3 buttons, jeans and gym shoes.

At the time of trial, Petitioner was still enrolled in a job search program and met with MedVoc's certified rehabilitation consultant, Kathleen Doehla, every other week. He does 5 applications in person and 5 online each week, predominantly looking for assembly work. He also participates in a home computer training program through MedVoc which he does 5 days per week. Petitioner stated he does 2 programs per day for 20-40 minutes for each program with little improvement in his computer skills. Progress reports from MedVoc Rehabilitation dated November 19 and December 28, 2016, February 2, March 10 and April 13, 2017 indicate that Petitioner continues in the vocational rehabilitation program through an in-home computer training program and job placement program. MedVoc continued to look for work for Petitioner and although Petitioner's computer skills are improving he continues to struggle with computers. (See PX.15)

Petitioner testified that he participated in a job search from October 2013 through July 2014 (10 months) and from March 16, 2016 through the time of hearing on April 27, 2017 (13 months). During this period, he has been on job interviews but not been offered any employment. He estimated that his last job interview was 10 or 11 months prior to trial.

Kathleen Doehla, a certified rehabilitation consultant testified via evidence deposition on November 16, 2016. (Super Mix RX.7) Ms. Doehla testified that Petitioner was evaluated in October 2013 and received job placement services until July 25, 2014. (Super Mix RX.7 p.10) Petitioner underwent vocational testing which included a cognitive assessment, the Woodcock-Johnson test, a career inventory assessment and training on interviewing techniques and skills and computer training. (Super Mix RX.7 p.12-13) Ms. Doehla testified that for the most part Petitioner was compliant with the job placement services provided. He was required to contact 10 potential employer contacts per week with 5 in person. (Super Mix RX.7 p.14) Petitioner began a second period of vocational assistance on March 8, 2016. (Super Mix RX.7 p.19) using his most current work restrictions. She testified that at the time of her deposition on November 16, 2016, Petitioner was maintaining the requirements of 10 employer contacts per week. (Super Mix RX.7 p.23) Ms. Doehla opined that because of his lifting restriction, Petitioner was employable at the modified medium work level. She also believed that continued vocational rehabilitation efforts would be beneficial. (Super Mix RX.7 p.29)

On cross examination, Ms. Doehla acknowledged that the vocational testing placed him below average in intellectual and verbal ability, both in the 29th percentile. She also acknowledged that Petitioner's mathematical calculation skills fell into the 6th percentile, also below average. (Super Mix RX.7 p.33-34) Ms. Doehla recounted that Petitioner had an interview at a prospective employer for a shuttle driver position; however, he was not offered the position due to his work restrictions. (Super Mix RX.7 p.42) Lastly, Ms. Doehla testified that she met with Petitioner every 2 weeks. She provided that Petitioner was always prompt for their meetings as well with potential employers or interviews. (Super Mix RX.7 p.48)

Mr. Edward Steffan, owner of EPS Rehabilitation was retained by Petitioner and testified that Petitioner was restricted from his previous occupation as of December 14, 2015. Mr. Steffan stated that according to the Department of Labor definitions, Petitioner's most recent restrictions placed him into the sedentary level of occupational activities. (PX.7 p.10-11)

Mr. Steffan met with Petitioner on April 1, 2016 and noted that Petitioner had a limited education having only completed freshman year of high school. He noted that growing up, Petitioner had been placed in special education classes. He noted Petitioner also tried, albeit unsuccessfully to obtain a GED at College of Lake County. Mr. Steffan felt same was significant because many employers require a GED or high school diploma for employment purposes. (PX.7 p.13) Mr. Steffan testified that the use of narcotic or opioid medication can affect one's concentration and ability to drive. (PX.7 p.12) He further testified because of Petitioners diagnosis of ADHD and treatment thereof with Adderall are often related to difficulties with learning and behavior. (PX.7 p.13) He further testified that prescription of narcotic medication would preclude any type of driving job. (Px.7 p.28)

Mr. Steffan testified that a singular work history makes it harder to place somebody in employment. He noted Petitioner's vocational history was limited to 16 years of driving a truck. He indicated this limits a vocational counselor ability to place Petitioner in other jobs. He testified that individuals with multiple types of job experience in different industries provides them with a broader range of skills, knowledge and experience which they can bring to bear on new employment options. (PX.7 p.14)

Mr. Steffan reviewed records from MedVoc Rehabilitation documenting that Petitioner engaged in a job search. Specifically, he noted Petitioner had applied online and submitted a resume to 103 potential employers. He noted Petitioner inquired and applied in person to 69 potential employers; inquired in person and was unable to complete an application on 40 occasions; and other job search activities which resulted in a total of 304 job search activities up through his own evaluation of Petitioner on April 1, 2016. (PX.7 p.17-18) Mr. Steffan's vocational rehabilitation plan was mostly similar to that of MedVoc Rehabilitation. (Id)

Mr. Steffan prepared a second vocational rehabilitation report dated October 28, 2016 after reviewing additional records from MedVoc Rehabilitation. At that time, he noted that Petitioner remained unable to secure employment; the placement program that was being utilized remained the same; the same type of job goals and that Petitioner continued in computer training. (PX.7 p.26) He noted that Petitioner and MedVoc had contacted approximately 273 potential employers in the 17 reports that he reviewed and was only interviewed on 3 or 4 occasions and received no job offers. Mr. Steffan stated the reasons for the lack of a job offer were the lack of a GED, Petitioner hadn't driven a truck recently enough to be hired, and the physical demands were beyond that of which Petitioner was capable of performing. (PX.7 p.27-28)

Mr. Steffan opined that Petitioner would not be able to induce a potential employer to hire him over other job applicants and therefore his inability to be competitive and compete with other applicants rendered him not placeable in a full-time gainful employment. Further he testified that the vocational rehabilitation program as presented by MedVoc Rehabilitation had not established a stable and readily available sedentary labor market in which Petitioner could be competitively employed. Petitioner's work history as a truck driver did not allow him to have usable transferable skills to sedentary occupations. (PX.7 p.29) On cross examination, Mr. Steffan conceded that although the record reflected that Petitioner was not employable and placeable, if additional services were performed, his opinion might change. (PX.7 p.31) He offered the gratuitous opinion that those services should be provided by his own company, EPS Rehabilitation. He further conceded that these services would be much the same as those services performed by MedVoc Rehabilitation. (PX.7 p.31)

With respect to (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Petitioner claimed one medical bill at trial as unpaid, from Lake Forest Hospital, the amount of $7,707.26. (PX 9) Respondent Super Mix agreed that the bill should be paid, if it is not a reduction per Fee Schedule or other arrangement. The Arbitrator awards this bill from Lake Forest Hospital in the amount of $7,707.26 as provided in Sections 8(a) and 8.2 of the Act. In the event this bill is paid, Respondent shall be given credit for same.

With respect to (K.) What temporary benefits (Maintenance) are in dispute, the Arbitrator finds as follows:

There are two periods of maintenance benefits in dispute: July 24, 2014 through August 19, 2014, and January 22, 2016 through March 5, 2016. No dispute exists between the parties as to other periods of TTD and/or maintenance.

For the period of July 24, 2014 through August 19, 2014, Respondent Super Mix disputes liability for benefits based upon vocational specialist Kathleen Doehla's report that Petitioner presented for a job interview with his fly open and he was not wearing underwear underneath. (Super Mix RX 7, pp. 38-39) Petitioner disputes these allegations. The Arbitrator notes that Petitioner was interviewed by Don at the Doubletree and in fact, Petitioner testified he received a call back for an interview from this employer. (Super Mix RX 7, p. 39) The reason Petitioner was not offered the job was due to his work restrictions.

The other period of January 22, 2016 through March 5, 2016, was after Petitioner had again been placed at maximum medical improvement by Dr. Vora on December 15, 2015. Petitioner engaged in a self-directed job search until vocational rehabilitation program with MedVoc Rehabilitation resumed on March 8, 2016. Petitioners job search efforts were recorded in Petitioner's Exhibit 8.

The Arbitrator is persuaded by Petitioner's testimony regarding the first period and awards maintenance benefits for same. The Arbitrator is also persuaded by Petitioner's testimony surrounding the second period and his efforts to find work on his own, although not as robust as when he was working with MedVoc. The total disputed maintenance benefits which the Arbitrator awards equals 9-6/7 weeks. The Arbitrator again notes that there is no other period of TTD or maintenance in dispute.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from September 29, 2011 until February 11, 2013; maintenance benefits from February 12, 2013 until August 19, 2014; temporary total disability benefits from August 20, 2014 until December 14, 2015; and maintenance benefits from December 15, 2015 through April 27, 2017. Respondent Super Mix is entitled to a credit of $242,309.85 for a combination of TTD/Maintenance benefits already paid for the aforementioned periods.

With respect to (O.) Is Respondent Super Mix a lending employer? Is Respondent Rock Solid a borrowing employer, the Arbitrator fins as follows:

The Arbitrator concludes that Respondent Super Mix is a lending employer and that Respondent Rock Solid is a borrowing employer.

An employee in the general employment of one employer may be loaned to another for the performance of special work and become the employee of the special or borrowing employer while performing such special work. *A.J. Johnson Paving Co. v. Industrial Commission*, 82 Ill.2d 341 (1980). The borrowed employee

doctrine is also specifically incorporated into Section 1(a)(4) of the Act. *Reichling v. Touchette Regional Hospital, Inc.*, 2015 IL App (5th) 140412.

In determining whether a borrowed employee relationship exists, two questions must be asked and answered:

1. Whether the alleged borrowing employer had the right to direct and control the manner in which the employee performed the work; and

2. Whether there was an express or implied contract of hire between the employee and the alleged borrowing employer. *A.J. Johnson Paving Co.*, 82 Ill.2d at 348.

In identifying the employer of a loaned employee the dominant circumstance is the right to control the manner in which the work is done. *Raymond Concrete Pile Co. v. Industrial Commission*, 37 Ill.2d 512 (1967), and *Suter v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 130049WC ¶13.

In this instance, the second question, whether there was a contract of hire, is easily answered. Petitioner testified that Respondent Super Mix asked Petitioner to go to North Dakota to help Jonathan of Respondent Rock Solid. Petitioner took his daily dispatch orders from Rock Solid employees or from Jonathan himself. Petitioner followed Rock Solid trucks to North Dakota and stayed with Rock Solid employees at a hotel. Jonathan acknowledged initiating a conversation with his father, Jack, about needing some of Jack's trucks and drivers. It is an easily reached conclusion that there was a contract of hire, either expressed or implied between Petitioner and Respondent Rock Solid. Petitioner's acceptance of the borrowing employer's direction demonstrates his acquiescence to the employee relationship. *Reichling v. Touchette Regional Hospital, Inc.*, 2015 IL App (5th) 140412 ¶30.

To answer the first question requires more analysis. The Court has identified several factors that are critical in determining whether the borrowing employer had the right to control and direct the manner of employee's work. These factors are whether:

1. The employee worked the same hours as the borrowing employer;

2. The employee received instructions from the borrowing employer's employees;

3. The loaning employer's supervisors were not at the worksite;

4. The borrowing employer told the employee when to start and stop working; and

5. The loaning employer relinquished its equipment to the borrower. *Morales v. Herrera*, 2016 IL App (1st) 153540 ¶24.

In analyzing each of these factors the Arbitrator concludes that Rock Solid is a borrowing employer and Super Mix is a loaning employer:

1. Petitioner testified he essentially worked the same hours as the Rock Solid employees;

2. Petitioner testified he received his daily dispatch orders the night before at the hotel from a Rock Solid employee. At the worksite, he received his orders from a Rock Solid employee;

3. It is undisputed that there were no Super Mix supervisors at the worksite in North Dakota;

4. Rock Solid told Petitioner when to start and when to stop working; and

5. Super Mix relinquished their equipment to Rock Solid, including the use of a Super Mix truck by a Rock Solid employee.

The Arbitrator also notes that Rock Solid had trucks similar to the one Petitioner drove at the jobsite. Jonathan acknowledged there was a general need for trucks at the jobsite and he initiated contact with his father to procure additional trucks.

Additionally, the contract between Rachel Contracting and Rock Solid is the only documentation indicating how Super Mix would be paid. This contract was apparently negotiated by Rock Solid, and not Super Mix. According to the testimony, Super Mix was not involved in that process. No other employers beside Rock Solid and Super Mix are noted in that contract.

Rock Solid argues that it did not have the right to discharge employee and that it did not pay Petitioner. The Court has said that these two factors do not defeat a finding of a loaned employee. *Morales,* 2016 IL App (1st) 153540 ¶24. Finally, it is of little consequence that Petitioner identified himself as an employee of Super Mix. Petitioner's personal definition of an employer has no bearing on whether Rock Solid is his employer as defined by Illinois law. *Morales,* 2016 IL App (1st) 153540 ¶30.

For all of the above reasons, the Arbitrator concludes that Respondents Rock Solid and Super Mix are jointly and severally liable to Petitioner under Section 1(a)(4) of the Act. The Arbitrator finds Rock Solid is the borrowing employer and therefore primarily liable to Petitioner. The Arbitrator finds Respondent Super Mix is the lending employer and therefore secondarily liable to Petitioner. There is no documentation of record that indicates that Super Mix agreed to be primarily liable for Petitioner's injuries.

With respect to (O.) Is Petitioner permanently and totally disabled, the Arbitrator finds as follows:

The Arbitrator acknowledges that to be permanently and totally disability pursuant to Section 8(f) under the odd-lot theory, an employee need not be reduced to total, physical and mental incapacity before total and permanent disability compensation can be awarded. E.R. Moore Co. v. Indus. Comm'n, 71 I11.2d 353, 376 N.E.2d 206 (1978). If a claimant's disability is limited in nature so that he is not obviously unemployable or if there is no medical evidence to support claim of total disability, burden is on claimant to establish unavailability of employment to person in his circumstances, but once he has established that he falls in "odd-lot" category, i.e., that he is one who is so handicapped that he will not be employed regularly in any well-known branch of the labor market but he is not altogether incapacitated for work, then burden shifts to employer to show that some kind of suitable work is regularly and continuously available to claimant. Valley Mould & Iron Co. v. Indus. Comm'n, 84 I11.2d 538, 419 N.E.2d 1159 (1981). In establishing whether the employee is unemployable, the Commission must evaluate the injured worker's age, training, education and experience (Id). An employee satisfies his burden of establishing that employment is unavailable to him by presenting evidence of a diligent, but unsuccessful job search or by showing that he is not regularly employed in a well-known branch of the labor market. Ameritech Services. Inc. v. Illinois Workers' Compensation Comm'n, 389 Ill.App.3d 191, 904 N.E.2d 1122 (1st Dist. 2009).

At time of hearing on April 27, 2017, Petitioner was 47 years of age. The highest level of education completed was ninth-grade. While in high school, Petitioner was enrolled in special education classes and diagnosed with ADD. Petitioner attempted but did not complete his GED as it was too difficult, he did not pass the GED preparation classes. Vocational testing placed Petitioner below average in intellectual and verbal ability, both in the 29th percentile and 6th percentile in mathematical skills, also below average. Petitioner's

entire work experience was limited to truck driving. Mr. Steffan noted Petitioner's vocational history was limited to 16 years of driving a truck which limits a vocational counselor to place him in other jobs. Mr. Steffan opined that individuals with multiple types of job experience in different industries give them a broader range of skills, knowledge and experience which they can bring to bear on new employment options. A singular work history makes it harder to place somebody. There is no dispute that Petitioner cannot return to driving. He cannot lift more than 40 pounds, is restricted from climbing of ladders or stairs, he may not stand and/or walk for more than 10 minutes per hour, he needs to use an ankle brace and cane as needed, no working at any heights and was to avoid uneven surfaces allowed only to work on flat surfaces. Mr. Steffan opined that this placed him into the sedentary level of occupational activities per the Department of Labor definitions. It was Ms. Doehla's opinion that Petitioner is employable at the modified medium work level because of the lifting restriction. Ms. Doehla testified that she met with Petitioner every 2 weeks and he was always prompt for their meetings as well as for meetings with potential employers or interviews. She testified that for the most part Petitioner was compliant with the job placement services provided. He was required to contact 10 potential employer contacts per week with 5 in person. Mr. Steffan reviewed records from MedVoc Rehabilitation documenting that Petitioner engaged in a job search. Specifically, Petitioner had applied online and submitted a resume to 103 potential employers, inquired and applied in person to 69 potential employers, inquired in person and was unable to complete an application on 40 occasions, and other job search activities which resulted in a total of 304 job search activities up through his own evaluation of Petitioner on April 1, 2016. Mr. Steffan then opined that after reviewing additional records from MedVoc Rehabilitation that as of October 28, 2016, Petitioner remained unable to secure employment. He noted that Petitioner and MedVoc had contacted approximately 273 potential employers in the 17 reports that he reviewed, was only interviewed on 3 or 4 occasions and received no job offers. Mr. Steffan concluded that the reasons for the lack of a job offer were the lack of a GED, that Petitioner hadn't driven a truck recently enough to be hired, and the physical demands were beyond that of which Petitioner was capable of performing. Mr. Steffan opined that Petitioner would not be able to induce a potential employer to hire him over other job applicants and therefore his inability to be competitive and compete with other applicants rendered him not placeable in full-time gainful employment. Mr. Steffan testified that the vocational rehabilitation program as presented by MedVoc Rehabilitation had not established a stable and readily available sedentary labor market in which Petitioner could be competitively employed stating that his work history as a truck driver did not allow him to have usable transferable skills to sedentary occupations. Mr. Steffan's opinion that if additional services were performed, his opinion might change and offered the gratuitous option that those services should be provided by his own company, EPS Rehabilitation, is nothing more than a solicitation for business.

At the time of trial Petitioner was still engaged in a job search program and met with Kathleen Doehla every other week and completes 5 applications in person and 5 online each week and participates in a home computer training program, however still struggles with computers. He has participated in a job search from October 2013 through July 2014 (10 months) and from March 16, 2016 through the time of hearing on April 27, 2017 (13 months). During this time, he has been on job interviews but have not been offered any employment. The Arbitrator concludes that Petitioner has performed a good faith and diligent job search over the course of 23 months and has been unable to secure a job.

Based upon Petitioner's age, his lack of education, his limited work experience, his lack of transferable skills, the sedentary permanent work restrictions and his diligent and unsuccessful job search, the Arbitrator concludes that Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Johnson,
Petitioner,

vs.

Sleep Innovations,
Respondent.

18IWCC0288

NO: 14 WC 21559

DECISION AND OPINION ON REVIEW

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

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

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: MAY 7 - 2018
o4/19/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0288

JOHNSON, DAVID
Employee/Petitioner

Case# **14WC021559**

SLEEP INNOVATIONS
Employer/Respondent

On 3/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK ET AL
HAYLEY GRAHAM SLEFO
161 N CLARK ST SUITE 2100
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

18IWCC0288

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Johnson
Employee/Petitioner

v.

Sleep Innovations
Employer/Respondent

Case # **14 WC 21559**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **2/8/17**. 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 **prospective medical care**

FINDINGS

On **4/29/2014**, 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 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 **$50,027.12**; the average weekly wage was **$962.06**.

On the date of accident, Petitioner was **56** 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** 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 $10,761.60 under Section 8(j) of the Act, representing non occupational disability benefits paid.

ORDER

Petitioner failed to prove the issue of accident. Therefore all 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

3/7/17
Date

MAR 8 - 2017

18IWCC0288

FINDINGS OF FACT

This case involves a Petitioner alleging that he sustained injuries while working for the Respondent on April 29, 2014. Respondent disputes Petitioner's claims and the disputed issues at trial were: 1) accident; 2) notice; 3) causation; 4) medical expenses; 5) TTD; 6) nature and extent; and 7) prospective medical care.

Petitioner was employed with Respondent from October 28, 2013 through May 9, 2014 as a maintenance technician, responsible for repair and upkeep of various machines in a mattress factory. He described having to climb on top of machines 8 to 10 feet tall, that there were few if any ladders or other devices to use, and that he frequently had to shimmy up and down the machines, using whatever small tables or chairs were nearby as a boost. On cross exam, Petitioner testified the only ladders were A-frames that could not be brought close enough to the tall rollpack machines to get up onto them. His duties had him all over the plant, which he described as three football fields in size, walking all day on concrete floors. He initially denied any prior problems with either foot before April 29, 2014.

He testified that while working on April 29, 2014 he was up atop an 8 to 10 foot rollpack machine, trying to loosen foam stuck at the top. He had used a small table to get up onto the machine, however, when he went to get down the table was no longer there. He described initially stepping backward down the side of the machine, landing on his right foot and then falling over. Later, he described being able to hold onto the top or side of the machine and sliding part of the way down, thus dropping about two to three feet onto his right foot. On cross exam, he testified he had been able to step up onto the table, which he estimated was about 3 ½ feet high, then to pull himself up onto the top of the 8 to 10 foot machine. He testified he performed this type of climbing activity to access machines, and was observed by his supervisor Dennis Giampaolo doing this, all the time.

He testified he felt immediate pain in the right foot but thought he could work through it. He testified this incident occurred about 11 a.m. that day, that he continued working the rest of his shift, another 3 ½ hours, and for the next several days. Payroll shows Petitioner working a full 8 hour day April 29, 8 hours April 30, 10 hours May 1, 10 hours May 2, 8 hours May 3, off Sunday, May 4, working 8 hours May 5, and then leaving work early May 6.

He testified he had had pain in his right foot before April 29, 2014, which he related to walking on concrete at work for Respondent, but that this right foot pain was different and became worse over the next several days. On cross, he testified he thought he'd been having right foot or bilateral foot pain since March, 2014.

Petitioner admitted he did not report the incident to anyone including Dennis Giampaolo. On May 6, 2014, he advised Dennis he was leaving work early for a doctor's appointment. He testified he told Dennis he was having pain in his right foot. He also testified he had been limping at work over the preceding couple of days. Dennis asked him if the right foot problem happened at work, and Petitioner told him he did not know. On redirect Petitioner testified he did not tell Dennis on May 6, 2014 about any injury to his right foot as he did not think he had an accident at work.

Petitioner sought medical care with Dr. Caneva, a foot doctor his wife had treated with. He admitted he did not tell Dr. Caneva about stepping off the machine at work or about any injury to his right foot sustained at work, until after Dr. Caneva told him he had a foot fracture. Dr. Caneva referred him to Dr. George, sent him for a foot MRI, and provided him a walking boot to wear.

18IWCC0288

Petitioner testified he called Dennis Giampaolo at work on May 13, 2014 to tell him he had been to a doctor, and that he had a fractured right foot and a doctor's note restricting his work duties. Petitioner testified he told Dennis he had been hurt at work, during this conversation. Dennis told Petitioner he had to talk to Cindy in human resources. On cross exam Petitioner testified he thought the conversation with Dennis was on May 12, 2014 and also admitted he did not tell him anything about a work injury.

Petitioner testified he never talked to Cindy but did email her about workers' compensation.

Petitioner initially saw Dr. George May 15, 2014 and told him how he had hurt his right foot at work. Dr. George prescribed a fusion, gave Petitioner work restrictions, and put Petitioner on crutches. Petitioner underwent surgery to his right foot July 16, 2014. He received no workers' compensation benefits while off, but did collect short term disability. On cross examination he admitted he had to claim his right foot problems and need for care were not work related in order to collect those benefits. His wife's insurance paid the medical bills.

Post operatively Petitioner had orthotics, therapy and a continued no work status. Dr. George released him to return to work with restrictions in October, 2014. Petitioner admitted he did not contact Respondent about returning to work in any capacity. He applied for and secured employment through a temporary agency, repairing small machines, and continued in that job until laid off in 2015. He did not look for other work. He applied for and is collecting Social Security disability. He is now on Medicare.

Petitioner developed an infection in his right great toe in January, 2015. Dr. George amputated that toe on January 26, 2015. On March 24, 2015, Dr. George released Petitioner with permanent work restrictions that included instructions to avoid standing, walking, climbing or jumping. Petitioner returned to Dr. George when the remaining toes on his right foot began curling under. Dr. George performed a pinning procedure in November, 2016. At the time of trial February 8, 2017, Petitioner testified he had a future visit with Dr. George the following day.

Petitioner testified that he currently experiences pain, worse with standing or walking. He talks three Tramadol a day, and avoids going places where he has to do much walking.

Dennis Giampaolo testified on behalf of the Respondent. He is the maintenance manager with Respondent, supervising 10 maintenance mechanics including Petitioner when he worked for Respondent. He works from 5 a.m. to 2:30 p.m., and thus would have been present during Petitioner's first shift and the start of the second shift at the plant. Petitioner would have received job assignments from Dennis or the leadman. When a machine malfunctions it is shut down and maintenance mechanics are called in.

Dennis described the rollpack machine as a machine that rolls 3 inch foam into a roll on a 36 inch high conveyor belt. Those rolls are then inserted by the machine into plastic bags on the conveyor. The bags are slid into the 6 foot tall portion of the machine, which compresses the air out of the bags for stacking and shipping. The highest part of the machine has gear boxes and spindles on top, making it 8 – 10 feet tall. With the gears on top, Dennis testified there is no way to stand on top of that machine. He also testified there is no loose foam in that machine, and thus no need to ever have to go onto of the rollpack to clear out loose foam. The only mechanical reason for accessing the top of the rollpack machine would be to address an oil leak, and Dennis testified there were none in April or May, 2014.

18IWCC0288

At any time the top of a rollpack has to be accessed, there are ladders nearby each tall machine as well as scissor lifts. There are extra ladders nearby in the storeroom. He could not recall anyone being unable to get a ladder or scissor lift, use a table or chairs to access the top of any machine, or anyone climbing up onto a machine as described by Petitioner. Respondent enforces safety policies with respect to proper climbing techniques.

Dennis testified Respondent's accident reporting procedure is to immediately tell him about it. He would get all the details and fill out the paperwork.

Dennis was working full time in April and May, 2014. He recalled Petitioner working full duty at that time, and did not ever see Petitioner limping or appearing to have any injury. He was not aware of any April 29, 2014 incident from any source.

On May 6, 2014 Dennis recalled Petitioner coming and advising him he needed to leave work early because of a doctor's appointment. Dennis told him this could count as an "occurrence" for possible termination because of the late notice. Dennis asked Petitioner if the doctor's appointment had anything to do with work, and Petitioner told Dennis it was "something in his past he needed to take care of."

Dennis recalled a phone call from Petitioner around May 12 or 13, asking about workers' compensation. Dennis asked him "for what injury," and Petitioner had no response. He was directed to follow up with Cindy. He recalled Petitioner coming in to pick up his tools, but had no further contact with him. Dennis testified he thought it was odd that Petitioner would be asking about workers' compensation, as he had never reported any work injury.

Cynthia Pinion also testified on behalf of the Respondent. She is the regional human resources manager for Respondent. She testified that the company accident reporting procedure is to immediately report any accidents to a supervisor, who assesses if emergency or other medical care is needed, and who fills out the paperwork. Employees are advised of the procedure on hire, and it is repeated all the time at safety or "town hall" meetings held frequently with employees. She was familiar with and often walks through the plant. There are ladders and scissor lifts to use to access any heights, as well as ladders near all the tall machines and a maintenance cage holding extra ladders near the rollpack machine Petitioner claimed to have been working on. She denied any employee ever needing to, or ever seeing any employee climbing on top of a rollpack or other machine. She described the tall end of the rollpack as a big gray box with no way to climb up it. She testified the machine is located right outside of her office. She recalled seeing Petitioner working, and did not recall ever seeing him walk with a limp.

Ms. Pinion testified that on May 14, 2014 she received an email from Petitioner asking about workers' compensation. Dennis was gone for the day so the next day, May 15, 2014, she asked him about any work injury. Dennis told her he only knew Petitioner had left work early on May 6 for a doctor's appointment, but expressly stated at the time it was for a prior problem and nothing work related. She did recall Petitioner telling her in the email exchange that he had a fractured foot, but also that the claimed date of accident was May 5, 2014. Ms. Pinion referred the matter to her workers' compensation carrier, and Petitioner's short term disability application to Cigna. She testified Petitioner would have had to claim a non work related problem in order to collect the short term disability benefits he received.

Dr. Caneva's records reflect he first saw Petitioner May 6, 2014. Petitioner completed a patient intake form indicating he had been having right foot problems for two months which "gradually developed over time" and

18IWCC0288

were worse with walking, standing and daily activities. The problem was not affecting his lifestyle or ability to work. He did not check "yes" to whether the problem was work related, and nowhere on the form did he indicate falling onto the right foot while climbing down a machine at work on April 29, 2014.

Dr. Caneva recorded a history of right heel pain present for two months, worse with walking and prolonged standing, and for which Petitioner had received "previous treatment" including rest and Mobic. Past medical history was significant for "foot pain" and "plantar fasciitis." Petitioner demonstrated swelling and tenderness with palpation to the plantar fascial band. X rays showed subluxation of the talor head, anterior beaking of the cyma line, subluxation of the Choparts joint, but no fracture. Dr. Caneva diagnosed plantar spurring of the os calcis, posterior spurring of the os calcis, and hammer toes two through five along with gouty arthritis, plantar fasciitis, onychomycosis and tibial tendonitis. He recommended rest, elevation, and stretching, orthotics, uric acid testing for gout, and referral to Dr. George. There is no history of any work injury sustained on April 29, 2014 in these medical records. (Pet.Ex.#1)

Petitioner completed an intake form for Dr. George's office May 12, 2014, on which he provided a history of foot pain since "April 12, 2014." The section in the medical records asking whether this was a work injury was left blank by Petitioner. Petitioner described right foot pain beginning approximately April 12, 2014, "all day," and "after a days work all day." He reported swelling which began a week earlier. He admitted to drinking four alcoholic beverages per day.

Dr. George's records further indicate that Petitioner reported dorsal and plantar foot pain with moderate swelling, numbness in the midfoot shooting into the first metatarsal phalangeal joint and hallux, with "pain in his right foot over the past several days leading up to . . . (seeing) Dr. Caneva on May 6, 2014." Physical exam showed some mild foot arthritis with pain over the talonavicular joint. X rays showed subluxation plantarly of the talar head of the navicular with disruption of the talonavicular joint and some irregularity in the lateral aspect of the navicular, for which Dr. George recommended a CAM walking boot, an MRI, and a "no work" status. There was no indication in this record that Petitioner sustained a work injury sustained on April 29, 2014.

The May 14, 2014 MRI of the right foot showed displacement or collapse of the anterior talus, a mildly displaced lateral navicular fracture, deemed from subcortical stress or an "insufficiency" fracture resulting in collapse, but for which post traumatic etiology could be considered if Petitioner had "sustained a recent trauma." Petitioner also had a high grade injury/tear of the dorsal talonavicular ligament, diffuse marrow edema suggestive of stress injury or change, midfoot arthrosis, diffuse inflammation, tenosynovitis, and chronic plantar fasciitis.

Petitioner returned to Dr. George May 15, 2014, reporting the problem began several days prior to May 5, 2014 and by that date he could no longer walk on his right foot. Dr. George reviewed the MRI as confirming the collapse he had suspected on x rays. He recommended surgical repair including a fusion.

Petitioner returned June 23, 2014, reporting only limited improvement with non weight bearing. Dr. George reiterated the surgical prescription. On July 16, 2014 Dr. George performed the right foot talonavicular fusion. Petitioner was placed on non weight bearing restrictions and prescribed a boot.

Dr. George completed a Cigna short term disability application showing care since May 12, 2014, with onset May 6, 2014 when Petitioner could no longer bear weight on the right foot, and that the condition was not work related. (Pet.Ex.2a)

18IWCC0288

Petitioner was prescribed orthotics September 30, 2014. (Pet.Ex.#2b)

On January 26, 2015 Petitioner underwent a right great toe amputation. There are no medical records from Dr. George immediately predating this surgery or setting forth the reason for the amputation. Dr. George diagnosed Charcot neuroarthropathy, deemed stable as of March 24, 2015. He cleared Petitioner to desk duty and discharged him at maximum medical improvement. (Pet.Ex.#2c) Dr. George later related the need for the great toe amputation to "alcoholic neuropathy" in his June 13, 2016 office note. (Pet.Ex.#2d)

Petitioner returned to Dr. George February 25, 2016 with report of "recurrent symptoms" in the right foot. A CT scan was ordered, performed March 3, 2016 and reviewed by Dr. George as showing neuroarthropathy secondary to alcoholic neuropathy, with severe collapse of the calcaneocuboid joint and talonavicular joint with failed hardware. Dr. George recommended a walker or further surgery but was "hesitant . . . as (Petitioner) still drinks." Petitioner was seen June 13, 2016 for a possible middle toenail infection. He was placed on Augmentin. Some hyperkeratotic tissue was debrided from some of the toes July 18, 2016. Petitioner reported a new injury to his right middle toe after he stubbed it on a dryer August 1, 2016. An ulcer developed on that middle toe. (Id.)

Petitioner underwent a hammer digit correction November 2, 2016. He reported some ongoing right foot pain, related by Dr. George to his alcoholic neuropathy December 1, 2016. Petitioner was treated for blisters on the first, third and fourth toes January 12, 2017 and was directed to follow up in a month. (Pet.Ex.#2e)

On December 11, 2015, Dr. George authored a narrative report at the request of Petitioner's counsel. He noted that he began seeing Petitioner March 12, 2014 for a right foot injury sustained as aforementioned on April 29, 2014, when he had a missed step coming off a machine on his right foot. Dr. George concluded this work injury caused the fracture and dislocation of the talonavicular joint. He acknowledged Petitioner had a pre existing neuropathy but felt the right foot condition was aggravated by the incident at work. He felt the immobilization following the right foot fusion caused the ulcer and thus the need for the right great toe amputation. (Pet.Ex.#3)

Dr. Vora conducted an IME on the Petitioner on June 13, 2014 at the request of Respondent. Petitioner described an injury "May 5, 2014, or sometime during that week," when he came down from a machine landing "awkwardly one time on his right foot." He continued to work, five days later noticed swelling and sought medical care. He denied any prior pain or injury, or "any problems prior to May 5." Dr. Vora noted the medical histories refuted the history provided to him by Petitioner, and showed symptoms before May 5, 2014, as indicated by Dr. Caneva two months before May 6, 2014, and as noted by Dr. George around April 12, 2014. Dr. Vora noted the talonavicular fracture, if traumatically caused, would have been severe enough that Petitioner would not have been able to continue working or walking on it. He suspected an underlying neuropathy as the cause. Dr. Vora did not believe there was any work related injury or cause for Petitioner's condition. (Resp.Ex.#2) Dr. Vora later reviewed additional medical records supporting the diagnosis of neuroarthropathy, which he continued to believe was the cause of all of Petitioner's right foot problems. (Resp.Ex.#3)

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the testimony of the various witnesses and the medical evidence. Essentially, this case boils down to a question of credibility. The Petitioner is alleging an

18IWCC0288

unwitnessed, traumatic incident occurred on April 29, 2014, wherein he claims he fell onto his right foot, thereby resulting in a fracture to that foot, his need for surgery, as well as the amputation of one of his toes. Petitioner claims that just prior to his accident, he had to use a table, which he stepped onto in order to climb onto a machine to remove some foam stuck in that machine. Between the time the Petitioner climbed onto the machine and the time he had to get down from the machine, this table mysteriously was moved; and as he was climbing down from the machine, he fell due to the inexplicable absence of said table. Petitioner's supervisor, Dennis Giampaolo testified that there were ladders and scissor lifts available for Petitioner's use. However, Dennis also confirmed that the machine Petitioner alleges to have fallen from would not require someone to climb onto to reach the top unless there was a leak – and there were no reported leaks on the date in question. Furthermore, the use of a table to climb up onto a machine would appear to be in violation of the safety protocols in the plant. Thus, if the Arbitrator were to take Petitioner's description of how he injured himself at face value, then it would seem Petitioner was violating the safety protocols of the plant at the time of his alleged fall.

But even putting the intentional violation of safety rules aside, Petitioner's claim is at odds with the medical evidence. Petitioner was able to work in his regular capacity for some time before he sought medical care and was take off work. In that time, he never reported an accident. When Petitioner requested time off from his supervisor to see a doctor and was asked by his supervisor about whether he was hurt at work, Petitioner responded, "I don't know." Petitioner did not mention he had a work accident when he contacted the Respondent's HR Manager, Ms. Pinion. When he first sought medical attention, he did not mention his fall at work. The medical records from Dr. Cavena show that the Petitioner had right foot problems for 2 months prior to his first visit. In reviewing the medical records, it appears that the first time that the Petitioner provided a description of injury to his right foot after stepping off a machine at work is to Dr. Vora, who noted that the Petitioner could not have continued to work if he had in fact sustained a traumatic talonavicular fracture. Dr. Vora's opinion that the Petitioner's foot problems are mainly due to neuroarthropathy is persuasive, given the other right foot problems that are noted in the medical records.

Given all these facts, the Arbitrator finds the Petitioner's claims less than credible. Petitioner's testimony is rebutted by Dennis Gianpaolo and Ms. Pinion. And the medical evidence does little in support of Petitioner's cause other than the solicited opinion provided by Dr. George at the request of Petitioner's attorney. As such, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment on April 29, 2014.

2. Based on the Arbitrator's conclusions with regard to the question of accident, all other issues are rendered 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

Gary Majewski,
Petitioner,

vs.

Wirtz Beverage,
Respondent.

18IWCC0289

NO: 15 WC 25425

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 disability, permanent disability, 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 April 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 7 - 2018
o4/19/18
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

18IWCC0289

MAJEWSKI, GARY
Employee/Petitioner

Case# **15WC025425**

WIRTZ BEVERAGE
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:

0307 ELFENBAUM EVERS & AMARILIO PC
KAROLINA M ZIELINSKA
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

2461 NYHAN BAMBRICK KINZIE & LOWRY
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

18INCC0289

18IWCC0289

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

Gary Majewski
Employee/Petitioner

v.

Wirtz Beverage
Employer/Respondent

Case # **15** WC **25425**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **March 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 **March 26, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,200.00**; the average weekly wage was **$1,100.00**.

On the date of accident, Petitioner was **55** 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

The Arbitrator finds Petitioner's condition of ill-being ended on in late June of 2015. Accordingly, medical bills after July 1, 2015 are denied.

The Arbitrator denies claims for TTD and TPD benefits, as Petitioner's lost time accrued after July 1, 2015.

The Arbitrator finds Petitioner sustained a cervical sprain that resolved approximately three months after the accident. As a consequence, Petitioner sustained permanent partial disability of 3% loss of use of a person as a whole pursuant to Section 8(d)(2) of the Act, equal to the sum of $660.00 /week for a period of 15 weeks.

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

April 4, 2017
Date

APR 4 - 2017

--STATEMENT OF FACTS

Respondent employed Petitioner since 2008 as a delivery driver for various beverages it sells. In that capacity, his duties were to drive loaded trailers and make deliveries at customer locations. The weight of the product delivered varies, and could weigh up to 45 pounds by Petitioner's report. Some deliveries necessitated the use of "dollies," or wheeled hand carts, as well as traversing up and down stairs. At times Petitioner used a dolly to carry product up the stairs.

Petitioner submitted a written description of his job into evidence as Petitioner's Exhibit 8. It contained a more detailed account of the physical requirements for a delivery driver. It relates a lifting maximum of 65 pounds. (Px8)

It is undisputed that on March 26, 2015 Petitioner injured his neck while working. At that time, Petitioner testified he was lowering the rear door of his truck and experienced pain and discomfort in his neck and trapezius region.

Prior Treatment

Prior to the March 26, 2016 accident, Petitioner testified that he had "the same thing" following a neck injury in 2008. He declined surgery and completed treatment in 2010. Petitioner testified that he declined surgery after conferring with Dr. Stadlan, who did not recommend a neck operation. Petitioner conceded during cross examination that surgery was recommended for many months, by more than one physician (Drs. Rubenstein and Dr. Templin), as late as 2011, and that he eventually declined surgery after he was notified that Wirtz would not pay for it.

Prior treatment records related to Petitioner's prior neck injury were admitted as Respondent's Exhibits 2 (MRI of 11/11/08), 3 (Hinsdale Orthopedic Associates, "Hinsdale") and 4 (Chicago Neurosurgery & Neuro Research, "CINN").

Petitioner underwent an MRI of his cervical spine on November 11, 2008. (Rx2) The radiologist concluded there was asymmetric disc bulging or herniation at C6-7 on the left with mild flattening of the spinal cord and mild narrowing of the left neural foramen, as well as asymmetric right-sided disc bulging at C7-T1. (Rx2)

Petitioner's prior treatment records relate he received care at Hinsdale with Dr. Cary Templin for his neck between May 14, 2010 and February 17, 2011. At the initial appointment, Petitioner reported neck pain that extended into the right arm in what Dr. Templin felt to be a C7 distribution. Dr. Templin noted that an MRI revealed "most notably that at C6-7 he has degenerative changes with foraminal stenosis, right greater than left. Petitioner was assessed with C7 radiculopathy. A repeat MRI was recommended. (Rx3, report of 5/14/10)

On May 17, 2010 an MRI of Petitioner's cervical spine revealed kyphotic angulation at C6-7 where there was a diffuse disc bulge, accompanied by central stenosis and neural foraminal narrowing. (Rx3, report of 5/17/10) Petitioner underwent a series of three epidural steroid injections with Dr. Samir Sharma during June and July of 2010. (Rx3)

Dr. Templin recommended surgery in the form of a C7-T1 foraminotomy on the right side on August 24, 2010. It specifically notes, "The patient wishes to proceed with this and therefore we will

go ahead and work on scheduling that." Full duty work was continued.

The most recent narrative report from Dr. Templin was dated November 8, 2010. Dr. Templin noted the findings of "an IME" with Dr. Lami and continued to recommend neck surgery. To that end, Dr. Templin stated that Petitioner wanted to proceed and would be contacted when the surgery was approved. (Rx3, report of 11/8/10)

The CINN records relate that Petitioner saw Dr. Stadlan for complaints of neck and low back pain between March 19th and September 24th of 2009. (Rx4) On March 19, 2009, Dr. Stadlan noted an MRI finding of foraminal stenosis on the right at C6-7 with some degeneration, and a left-sided disc herniation at the same level. Petitioner was assessed with neck pain that appeared to be cervical radiculopathy. Physical therapy and traction were recommended. (Rx4, report of 3/19/09) By May 18, 2009, Petitioner reported improvement and was released. (Rx4, report of 5/18/09) Dr. Stadlan stated that he did not feel surgery would be "particularly beneficial" when he saw Petitioner on September 24, 2009. (Rx4, report of 9/24/09) The Arbitrator notes that Petitioner saw Dr. Stadlan prior to coming under the care of Dr. Templin, the latter of which felt surgery to be necessary.

Prior Cases for Work Injuries

Petitioner acknowledged he filed three prior applications against Respondent. Case 10 WC 39561 concerned a neck injury on 10/28/2008. The other two claims (10 WC 39562 and 14 WC 19518) concerned left leg injuries. All three cases were consolidated and settled contemporaneously. Settlement contracts were approved on

March 5, 2015, exactly three weeks before the accident in this presently pending case.

Treatment for March 26, 2015 Accident

Petitioner initially sought treatment at U.S. Healthworks, Respondent's clinic, on March 27, 2015. (Px7) The report from that date contained a history of a right-sided neck injury when pulling down the overhead door of his trailer yesterday. The report expressly indicates there was no numbness or tingling down the right arm, nor right arm weakness. In the "Patient Information" form, the pain was rated 7 on a 1-10 scale. A pain diagram completed by the provider contains a mark for tenderness at the level of the chin on the right side of Petitioner's neck. The past medical history provided only mentioned a prior left knee injury. Petitioner was diagnosed with a neck sprain, given work restrictions, and prescribed Naproxen.

The US Healthworks records also contained an accident report signed by Petitioner. (Px7) It described sharp pain in the right side of the neck after pulling down an overhead door.

Petitioner returned to U.S. Healthworks on April 3, 2015. He was diagnosed with an improved cervical strain. It was noted that Petitioner was seeing an orthopedic special and discharged from care.

Petitioner came under the care of Dr. Anthony Rinella of Illinois Spine and Scoliosis on April 1, 2015. (Px2) Petitioner complained of tenderness in the right trapezial area for the past six days after closing the door of his truck at work. The pain was rated 6-8 out of ten, and did not radiate distally. The diagnoses were a cervical strain and cervical spondylotic radiculopathy. Although Petitioner brought a

disc with his MRI from 2010, Dr. Rinella could not access the films. Physical therapy was prescribed and work restrictions were issued.

Petitioner also saw Douglas Stevens, Dr. Rinalla's Physician Assistant, in the stead of Dr. Rinella. Of Petitioner's 16 total examinations at Illinois Spine and Scoliosis, they were split equally in half between Dr. Rinella and Mr. Stevens (8 times each). (Px2)

Mr. Stevens ordered an MRI on May 1, 2015. On May 13, 2015 Dr. Rinella interpreted the study as revealing kyphosis at C6-7 with an associated disc herniation. The diagnoses were changed to a cervical strain, cervical spondylotic radiculopathy secondary to a disc herniation, and right upper extremity weakness. Continued physical therapy and injections were recommended.

Petitioner attended physical therapy at ATI for 24 sessions between April 2, 2015 and May 28, 2015. (Px5). He attended four weeks of work hardening during June of 2015. The last report for the period of June 22, 2015-June 28, 2015 found Petitioner had progressed to the "VERY HEAVY" physical demand level, but continued to complain of constant neck pain. (emphasis in original) It was specifically noted that Petitioner met the demand of his job of lifting 65 pounds. (Px5, p. 66) More specifically, Petitioner demonstrated the ability to lift 105 pounds from floor to chair height 10 times, overhead press 65 pounds six times, and lift and carry 80 pounds 100 feet. *Id.*

On June 11, 2015, Petitioner saw Mr. Stevens, who recommended relaxed work restrictions of a 25 pound limit (from ten at the time), and an EMG. (Px2)

Mr. Stevens saw Petitioner again on June 26, 2015. Petitioner was released to unrestricted work. (Px2, p.20) Grip strength as well as strength throughout the triceps, biceps, and deltoids was normal.

Petitioner returned to Dr. Rinella on July 29, 2015. On that date he complained of a flare up of symptoms after returning to work on a different route. (Px2, p.22) Work restrictions were reinstated of a 25 pound weight limit and no overhead work. An EMG and injections continued to be recommended. Dr. Rinella reviewed an IME report of Dr. Lami, who it was noted disagreed with the diagnosis of cervical radiculopathy. *Id.*

Dr. Sharma administered an injection into Petitioner's neck on August 31, 2015. (Px2, pp. 27-38) Petitioner reported 75% relief for about 3-4 days.

On September 25, 2015, Mr. Stevens stated, "I suspect he will require at least a C6-7 anterior cervical discectomy and fusion." (Px2, p.40) Petitioner was encouraged to proceed with a second injection, which was done on October 7, 2015. (Px2, pp.40-44)

Mr. Stevens "anticipated" a C6-7 discectomy and fusion when Petitioner returned to Illinois Spine and Scoliosis on October 28, 2015. (Px2 p.50)

Petitioner underwent an EMG/NCV on November 16, 2015. (Px2, p.50) It revealed bilateral medial neuropathies at the wrists, a mild, chronic right c6-7 cervical radiculopathy without "active denervation," and a moderate right ulnar mononeuropathy localized to the forearm or wrist.

Dr. Rinella discussed an anterior cervical discectomy and fusion at C6-7 with Petitioner on November 18, 2015. (Px2, p.56)

Petitioner desired to proceed with surgery. The surgery proceeded on February 23, 2016. (Px2, pp. 61-62)

Petitioner's first postoperative appointment was with Mr. Stevens on March 3, 2016. (Px2, p.65) He was restricted from work and a bone growth stimulator was recommended along with a cervical collar. Postoperative physical therapy was recommended on April 7, 2016. (Px2, p.69)

Petitioner returned to ATI for physical therapy and work conditioning between April 18, 2016 and July 14, 2016. (Px5, pp. 143-230) At the conclusion of that treatment, it was noted that Petitioner had "minimal neck pain" with a primary complaint of right upper extremity radicular symptoms.

On July 14, 2016, Petitioner was discharged by Dr. Rinella. (Px2, p.72). Concerning work, Petitioner was placed at "full duty with a permanent helper."

Petitioner's final medical appointment was with Mr. Stevens on August 5, 2016. (Px2, p.74) Petitioner continued to complain of numbness and weakness in his right hand. He was "struggling with" his work restrictions. The Arbitrator notes that Petitioner had not returned to work for Respondent at this time. Mr. Stevens then issued permanent work restrictions of 50 pounds lifting, with no repetitive bending or twisting. (Px2, p.75) Although there were mentions about a possible FCE in the ATI therapy records (Px5, p.149), one was never done.

Dr. Rinella Deposition

Dr. Rinella testified in this case via evidence deposition, with the transcript admitted as Petitioner's Exhibit 1. Dr. Rinella testified about the treatment recited above by the Arbitrator. (Px1, pp.1-25)

Concerning Petitioner's July 14, 2016 exam (Dr. Rinella's last) and Petitioner's ability to return to work, Dr. Rinella stated, ""Well, we both thought he could return to work full-duty… I thought he would benefit from a helper." (Px1, pp. 17-18) Dr. Rinella felt a helper, "could, obviously, have someone help him with repetitive overhead activities, things of this nature." (Px1, p.19) Dr. Rinella added, "that's why I didn't given him any restrictions. I said, Go work full-duty," but a helper could limit overall risk. *Id.*

Dr. Rinella did not speak with Petitioner when Mr. Stevens offered permanent restrictions on August 5, 2016. (Px1, pp. 26-27) Dr. Rinella testified, "I really wish I could tell you exactly why that modification was necessary, but I don't know." (Px1, p.27) When asked why an FCE was not ordered Dr. Rinella added, "Well, in this case, I didn't believe he—when I gave him the restrictions, **I didn't think he needed them.**" (emphasis supplied) (Px1, p.33)

Dr. Rinella saw no diagnostic records from prior to Petitioner's accident of March 26, 2015. (Px1, p.27)

Concerning the extent of Petitioner's radiculopathy, Dr. Rinella testified that it only extended only into the shoulder. (Px1, p.37) He added, that the lack of radiculopathy "following the exact textbook pathway" doesn't eliminate its existence, and "for it to be cervical in nature, it usually has to go through the trapezial area and then work to wherever it's going to go." (Px1, p.36)

Dr. Rinella believed that Petitioner had a successful and uncomplicated recovery from his fusion, evidenced by the typical duration and type of treatment for a good result. (Px1, p.38)

When asked if the physical therapy notes demonstrate the ability for Petitioner to perform the duties in the written job description, Dr Rinella said it was agreed when Petitioner was given no restrictions, and "most importantly, to me, he felt he could do this job. And I think – If you're point was to show those numbers suggest he could do this job, I was in agreement with that." (Px1, p.45-46)

Dr. Lami Section 12 Examinations and Deposition

Dr. Lami examined Petitioner for his neck on multiple occasions at the request of Respondent, including prior to the March 26, 2015 accident. (Rx1) Dr. Lami also testified in this case via evidence deposition, the transcript of which was admitted as Respondent's Exhibit 1.

Dr. Lami first examined Petitioner on September 1, 2010. (Rx1, p.6) At that time, Dr. Lami reviewed the treatment records from Petitioner's October 28, 2008 accident and corresponding complaints of neck pain, including the films from MRI related thereto. (Rx1, pp.8-10) That included a recommendation of Dr. Rabinowitz on November 21, 2008 recommending a C5-7 anterior discectomy and fusion. (Rx1, p.9) Dr. Lami felt Petitioner had strained his neck and could resume unrestricted work. (Rx1, pp.10-12)

Dr. Lami examined Petitioner after the March 26, 2015 accident on June 11, 2015. (Rx1, p.12) for that exam Dr. Lami reviewed Petitioner's May 17, 2010 MRI, which revealed a C6-7 disc bulge,

with central canal stenosis and left foraminal narrowing, with a disc herniation at C7-T1. (Rx1, p.16)

Dr. Lami found significant that Petitioner did not complain of distal radiating pain when first seen by Dr. Rinella as significant evidence of the absence of radiculopathy. (Rx1, pp. 18-19) Regarding whether Petitioner had radiculopathy, Dr. Lami testified, that he would expect the condition from a traumatic incident to present within 72 hours, using the metaphor, "If I poke you in the eye, you'll feel it today," but it did not. (Rx1, p.19).

Dr. Lami personally reviewed the May 13, 2015 MRI. (Rx1, p.20) After a physical exam of Petitioner, Dr. Lami diagnosed Petitioner with a neck sprain and did not feel that the degeneration in Petitioner's cervical spine was aggravated. (Rx1, pp. 20-22, 24-25) Dr. Lami believed that a couple more weeks of work conditioning would be appropriate and while Petitioner was "essentially" at maximum medical improvement, would be at the conclusion of work conditioning. (Rx1, p.26)

Dr. Lami testified that Petitioner was not a surgical candidate and capable of unrestricted work following the June 11, 2015 exam, or immediate if Petitioner chose to forgo further work conditioning. (Rx1, pp.26-27, 39-40)

Dr. Lami re-examined Petitioner on September 23, 2016, and updated treatment records were reviewed. (Rx1, pp.27-31, 33-35) Dr. Lami's opinion remained unchanged that Petitioner sustained a neck sprain due to his work accident, for which no further care was needed after about June 24, 2015. (Rx1, pp.35-38) According to Dr. Lami, Petitioner could still resume unrestricted work. *Id.*

Nevertheless, despite surgery, Dr. Lami noted that Petitioner had the "same symptoms" postoperatively despite an uncomplicated surgery, as he did before the operation. (Rx1, p.38)

CONCLUSIONS OF LAW

In regards to issue (f), whether Petitioner's condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's current condition of ill-being relates to his accident of March 26, 2015.

In so findings, the Arbitrator finds the opinions of Dr. Lami more persuasive than those of Dr. Rinella. In that regard, Dr. Lami is the lone physician in this case to have examined Petitioner prior to his March 26, 2015 accident. Moreover, Dr Lami is in the exclusive position to have review Petiitoner's pre-accident and post-accident MRIs. The Arbitrator finds these facts extremely compelling.

The Arbitrator rejects the opinions of Dr. Rinella. In doing so, the Arbitrator disagrees with Dr. Rinella that radiculopathy that doesn't extend past the shoulder that doesn't comport with a "textbook" presentation is not supportive of an active radiculopathy. Instead, the Arbitrator relies upon Dr. Lami's opinions, and specifically that clinically radiculopathy should follow a dermatomal pattern established by medical and that Petitioner's complaints did not.

Accordingly, the Arbitrator finds that Petitioner sustained a cervical sprain. That condition resolved as indicated by Dr. Lami within a couple weeks of his June 11, 2015 exam, or no later than

Concerning Petitioner's overall veracity, the Arbitrator finds Petitioner to be less than truthful about the nature of his neck injury from 2008, especially concerning his stated level of desire in undergoing surgery at that time.

The Arbitrator also finds compelling that Petitioner sustained the March 26, 2015 accident in such close proximity to when his earlier neck case resolved (exactly three weeks).

The Arbitrator further notes that despite surgery, the work hardening records indicated shortly before Petitioner's discharge that he still complained of right arm radicular problems. This evidences that the surgery did not resolve the right upper extremity complaints with which Petitioner presented prior to surgery, and that surgery did not solve his arm/hand problems.

In regards to other issues, including (l), the nature and extent of Petitioner's injuries, the Arbitrator finds as follows:

The Arbitrator finds all remaining issues except permanency moot.

Petitioner sustained a neck sprain. The condition resolved in approximately three months.

When considering Section 8.1b factors, the Arbitrator notes:

1. No impairment report was submitted.
2. The age at the time of injury is close to the end of one's expected work life and favors lower permanency.

3. Petitioner's pre-injury job was physically demanding, substantially favoring higher permanency.
4. There is no impact on future earnings. Petitioner was released to full duty, but could aid from someone's help. That isn't a limitation personal to himself.
5. Residual complaints and problems are mild and minor. Complaints of ongoing numbness may best be explained by neuropathy from the wrists and forearms instead of the neck,

The Arbitrator finds Petitioner sustained disability to the extent of 3% loss of use of a whole person, or 15 weeks. Petitioner sustained a neck strain that resolved within about 3 months.

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

☐ 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

CHAD M. DELP,

Petitioner,

vs. NO: 12 WC 39031

JOHN DEERE,

Respondent.

18IWCC0290

DECISION AND OPINION ON §19H/§8A PETITION

A §19h/8a Petition having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner Gore on July 7, 2017. The issue under the §19h/8a Petition is whether or not the Petitioner has established a material increase in his condition of ill-being which is causally related to the work accident. The Commission having jurisdiction over the persons and subject matter, and after being advised in the premise, finds:

1. Petitioner injured his left ankle on July 19, 2011. He fractured his ankle and subsequently had a plate inserted. He has not injured his ankle in any way since then, and worked for Respondent until approximately 2013 or 2014.

2. After the accident, Petitioner had pain when walking up stairs or doing any activities of daily living around his home.

3. On May 17, 2013 the Arbitrator filed a Decision finding causation and awarded permanent partial disability (PPD) benefits of a 37.5% loss of use of Petitioner's left foot under §8(e) of the Act.

4. Immediately after the 2013 Arbitration hearing, Petitioner had normal pain walking up stairs.

5. Petitioner eventually sought additional treatment for his ankle at Orthopedic & Rheumatology. Dr. Connolly gave him some advice and eventually referred him for therapy.

18IWCC0290

6. Petitioner underwent 12 therapy visits. Towards the latter part, he was walking and running up stairs, which helped his condition. He now has minimal to no ankle issues other than walking up and down stairs or getting in and out of his truck and pushing items off of his trailer.

7. Petitioner subsequently worked for Stern Beverage, FedEx and Ruan Transportation.

8. Petitioner is currently a Truck Driver for Hoovestool. When he drives to Omaha he only drives. When he drives to Chicago, he loads the truck, drives and unloads. He testified that he is able to handle these duties, although he stated he was dealing with ankle pain when loading and unloading his trailer.

9. Petitioner testified that he had sharp pain in his left knee while employed for the three above-named employers subsequent to his employ with Respondent.

10. Petitioner admitted that he had pain walking stairs after breaking his ankle in 2013. He currently does not take any medications and has had no additional surgeries. He also has no work restrictions. He denies any specific new ankle injury since Arbitration.

The Commission finds that medical records do not indicate any material change in his ankle condition that would warrant an increase in his PPD award. Petitioner admitted that he had pain traversing stairs prior to the conclusion of the 2013 Arbitration hearing. This pain seems to be a continuation of the pain he had at arbitration, rather than a material increase. Accordingly, the Commission denies Petitioner's §19(h)/§8(a) Petition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §19(h)/§8(a) Petition be denied.

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

MAY 7 - 2018

DATED:
DLG/wde
O: 3/8/18
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DELP, CHAD M
Employee/Petitioner

Case# **12WC039031**

JOHN DEERE
Employer/Respondent

18IWCC0290

On 5/17/2013, 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 0.08% 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:

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

2119 CALIFF & HARPER PC
STEVE L NELSON
506 15TH ST SUITE 600
MOLINE, IL 61265

18IWCC0290

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
NATURE AND EXTENT ONLY

CHAD M. DELP,
Employee/Petitioner

v.

JOHN DEERE,
Employer/Respondent

Case # **12** WC **39031**

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 **Maureen H. Pulia**, Arbitrator of the Commission, in the city of **Rock Island**, on **5/7/13**. By stipulation, the parties agree:

On the date of accident, **7/19/11**, 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 $**29,291.60**, and the average weekly wage was $**563.30**.

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 $**600.88** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**600.88**.

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 $**337.98**/week for a further period of **62.625** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **petitioner a 37.5% loss of use of his left foot**.

Respondent shall pay Petitioner compensation that has accrued from **7/19/11** through **5/7/13**, 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

5/7/13
Date

MAY 17 2013

Trial Notes	**Case: 12 WC 39031** **Case Name: Chad M. Delp v. John Deere** **Consolidated:** **Trial Date: 5/7/13**
Court Reporter:	Sheila
Date of Accident:	7/19/11
Case Type (19(b), 8(2), N&E):	Reg
Petitioner's Atty:	John Mitchell
Respondent's Atty:	Steve Nelson
Alleged Injury:	Left ankle
Issues:	cc-nc
Wage Rate:	$29,291.60/$563.30
Interpreter:	
Stip Sheet Completed:	Yes
Exhibit List Completed:	Yes
Envelopes Completed:	Yes
Preliminary Matters	
Proposed Decision Due Date:	Yes

WITNESS: Chad Delp
DOA: 7/19/11

high schhol grad
blackhawk college - degree or cert in welding

baseball b4 acc
activities- outdoor-sports

started for R 6/11

title- woodshop-fork truck driver
flipping a big part in woodshop- lifted part of forklift - part fell on his left ankle- tractor frame - 2000 lb- fell on left foot and ankle

taken to Trinity Medical - after R medical

had alot of pain in the ankle

exam and xrays of ankle

referred to Connoly- 7/20/11- ortho- put splint on foot/ankle
restrictions for work

rtw for an hour - then sent home by R

fu Connoly 7/27/11- cast on lower leg

would go in ach day and they set home

fu connolly - 9/6/11- CAM boot

PT in plant

noticed stiffness - no flexibility-pain
was taking hydrocodene

P discharged -

saw dr in med dept

ankle not right -

still had pain , limited flexibility
could not jog

more x-rays - 3/14/12 at Trinity had CT scan

3.29/12 saw Connolly - fx

5/12/12- ORIF ankle
off work after that for a while

fu Connolly

discharged

still works for John Deere

NOW- still stiffness- can run a little - cant kneel like he used to has pain scarring-
sharp pains occasionally

when run - lags as compared to other leg

kneeling

takes ibuprofen as needed

doing same job

hurt ankle - broke growth plate while in school

last week - got hit in same ankle -

CROSS EXAMINATION '

last saw 7/19 /12 connolly

works with no restrictions now in same job
works overtime as needed

11/11/12- c/o pain after playing football - played for a 1/2/hr
runs every other day or so for an hour

EXHIBITS
PX1-3

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

ORVILLE H. ALMS, JR.,

Petitioner,

vs. NO: 16 WC 10334

SOUTHERN ILLINOIS UNIVERSITY-CARBONDALE,

Respondent.

18IWCC0291

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §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 and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner is employed as a Bindery Operator II by Respondent. He had held this position for 4-1/2 years on January 5, 2016. He operates several different kinds of cutting, binding, folding and stitching machines, cuts paper, loads signatures into a saddle stitcher machine, loads sheets into a folder, and catches sheets off the folder and stacks them. When not

doing this, Petitioner works in another department hand-stuffing magazines into envelopes, hole-punching papers and occasionally operating inserter machines.

2. When operating the cutting machine, Petitioner takes a 5 to 15-pound stack of 23x35 or 28x40 sheets and stacks them into a machine and cuts them. He then takes the cut sheets and delivers them to either the press or the duplicating machine.

3. The Saddle Stitcher inserts stitches into the spine of a book. Petitioner cuts the forms, folds them on the folder, takes them to the saddle stitcher and loads them into the hopper.

4. Petitioner worked seven hours per shift, including two fifteen-minute breaks and a thirty-minute lunch. Five hours were spent using his hands in a gripping fashion. He has wrist flexion the entirety of his shift.

5. Petitioner had no prior complaints or diagnoses related to his carpal tunnels bilaterally.

6. On January 5, 2016 Petitioner was stuffing magazines in envelopes. After his break, he noticed his hands were going to sleep. He had noticed symptoms before, but not to this extent. His fingers would go numb and he began dropping items. He also had tingling.

7. On January 19, 2016 Petitioner underwent an EMG, which revealed bilateral carpal tunnel syndrome, left greater than right. Petitioner was prescribed a wrist brace, which did not relieve his symptoms.

8. Petitioner eventually sought treatment with his primary care physician (PCP) Dr. Krieg. A February 1, 2016 EMG and nerve conduction study confirmed a diagnosis of bilateral carpal tunnel syndrome.

9. Petitioner was referred to Dr. Mall in April 2016. Dr. Mall examined Petitioner and reviewed his nerve conduction study, subsequently finding a diagnosis of bilateral carpal tunnel.

10. After additional conservative measures failed, bilateral carpal tunnel releases were recommended by Dr. Mall.

11. Petitioner underwent an independent medical exam (IME) with Dr. Sudekum. Dr. Sudekum testified that he had Petitioner undergo a nerve conduction study. Dr. Sudekum found osteoarthritic changes in both hands and elbows, chronic medial and lateral elbow tendinitis, mild swelling and tenderness of the left forearm, and wrist symptoms consistent with forearm flexor tendinitis. He found no evidence of carpal tunnel syndrome in medical records, and indicated that if Petitioner was suffering from carpal tunnel syndrome, he would have complaints of numbness and tingling in his thumb, index and middle fingers.

18IWCC0291

12. Dr. Sudekum opined that Petitioner's clerical tasks were not sufficient in duration or type of movement to cause carpal or cubital tunnel syndromes. He also opined that there were other risk factors that could contribute to Petitioner's conditions.

13. Dr. Mall noted osteoarthritis, but in Petitioner's DIP and PIP finger joints, which are far away from the carpal tunnel. He also noted no other risk factors for Petitioner's carpal tunnel syndromes. Petitioner was not diabetic, was not obese, did not have hypertension and did not have osteoarthritis in his wrists. He opined that Petitioner's job duties were a major factor in the development of his syndromes.

The Commission affirms the Arbitrator's findings of accident and causal connection related to Petitioner's forearm flexor tendinitis. The Commission also affirms the Arbitrator's denial of causal connection in relation to Petitioner's bilateral cubital tunnel syndromes.

The Commission also affirms the Arbitrator's evidentiary ruling allowing Dr. Sudekum's testimony regarding the findings of his nerve conduction study, despite Respondent failing to admit the actual study itself into evidence.

The Commission, however, modifies the Arbitrator's ruling in relation to Petitioner's bilateral carpal tunnel syndromes. The Commission finds sufficient objective evidence of bilateral carpal tunnel syndrome in the medical records. Dr. Sudekum testified that the thumb, index and middle fingers are hampered by numbness and tingling when carpal tunnel is present. Dr. Sudekum himself admitted that Petitioner complained of numbness in these fingers during his IME. These symptoms remained consistent, as Petitioner also complained of said numbness during physical therapy in March and April of 2017. Thus, the record contradicts Dr. Sudekum's opinion and reasoning. Furthermore, the record clearly shows January and February 2016 EMG's revealing evidence of bilateral carpal tunnel syndrome, which also contradicts Dr. Sudekum's testimony of no objective evidence of carpal tunnel.

The Commission finds causation with respect to Petitioner's bilateral carpal tunnel syndrome (in addition to the already awarded flexor forearm tendinitis). Petitioner had no prior medical complaints or diagnosis of carpal tunnel, engaged in repetitive gripping and grasping while working for Respondent, and exhibited objective and subjective evidence of bilateral carpal tunnel syndrome.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's bilateral carpal tunnel syndromes are causally related to his work accident of January 5, 2016. This is in addition to the finding of causal connection to Petitioner's forearm flexor tendinitis.

IT IS FURTHER ORDRED BY THE COMMISSION that Respondent shall be liable for prospective medical care in the form of bilateral carpal tunnel releases, as well as any post-surgical physical therapy and related treatment.

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 $2,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 7 - 2018
O: 3/8/18
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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

ALMS JR, ORVILLE H
Employee/Petitioner

Case# **16WC010334**

SOUTHERN ILLINOIS UNIVERSITY-CARBONDALE
Employer/Respondent

18IWCC0291

On 9/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4852 FISHER KERKHOVER COFFEY
JORDAN GREMMELS
1300 1/2 SWANWICK PO BOX 191
CHESTER, IL 62233

0558 ASSISTANT ATTORNEY GENERAL
SHANNON RIECKENBERG
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

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

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

SEP 12 2017

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

18IWCC0291

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
19(b)

Orville H. Alms, Jr.
Employee/Petitioner

v.

Southern Illinois University - Carbondale
Employer/Respondent

Case # 16 WC 10334

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 **August 2, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0291

FINDINGS

On the date of accident, **January 5, 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 **of left forearm flexor tendinitis** *is* causally related to the accident but Petitioner's condition of carpal tunnel syndrome and cubital tunnel syndrome *is not* causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$48,826.96**; the average weekly wage was **$938.98**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Respondent shall authorize the treatment for the left forearm flexor tendinitis as recommended by Dr. Sudekum, including, but not limited to, the recommended evaluation and treatment by a certified occupational therapist.

Respondent shall pay the reasonable and necessary medical services as contained in **Petitioner's Exhibit 6** 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 provider(s). 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 benefits paid under its group health plan under 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.

Melinda M. Price-Sullivan
Signature of Arbitrator

9/8/17
Date

ICArbDec19(b)

SEP 12 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Orville H. Alms, Jr.
Employee/Petitioner

Case # 16 WC 10334

v.

Consolidated cases: N/A

Southern Illinois University - Carbondale
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently employed with Respondent as a Bindery Operator II. He testified that he had been so employed for approximately 4½ years at the time of the accident. He testified that he is left-hand dominant.

As to his job duties, Petitioner testified that he operated several different kinds of machines including cutting, binding, folding and stitching machines, as well as cutting paper, loading signatures into a saddle stitching machine, loading sheets of paper into a folder, catching the sheets off the folder and stacking them and packaging the items for shipment. He testified that he would have to do hand-intensive work such as stuffing envelopes, hole punching and the running of spiral or coil bindings. He testified that when using the cutting machine, he would be working with anywhere from 23x35- to 28x40-sized sheets of paper. He testified that he would load stacks of paper into the machine and cut them down to be run on the press or folder, that he would have to pick up the paper in small sections (anywhere from 5-15 pounds), and that he would load them into the machine and cut them into smaller sizes. He testified that after the cutting was complete, he would stack the papers and deliver them to the press or the duplicating machine.

Petitioner testified that when he ran the saddle stitcher, he would cut forms on the cutting press, fold them onto the folder and then the hoppers would be loaded. He testified that the bundles would have to be jogged by hand to verify consistency. He testified that he would have to pick up bundles of paper and physically bend them to fit into the saddle stitcher. He testified that these bundles would weigh approximately 2-3 pounds and would be about 9x12 in size. He testified that when packaging the booklets, he would have to scoop up the bundles, place them on a table and jog them down. He testified that after this was completed, he would then load them into a box or carton for shipment. He also testified as to his job duties when operating the folder as well. He testified that he would load anywhere from 8.5x11- to 23x35-inch sheets into the folder and fold it down to the various configurations required for the job.

On cross-examination, Petitioner explained that his job would be more labor intensive prior to new semesters or large events at SIU. On redirect, Petitioner testified that in January of 2016, his job would have been more intensive due to the coming spring semester.

Petitioner also testified regarding his prior work history. He testified that he worked at Spartan Printing approximately 30 years ago, performing many of the same jobs that he does now. He testified that he had a prior left elbow surgery during his time at Spartan Printing. He testified that he had no further complaints with respect to his upper extremities between his time at Spartan Printing and his date of injury.

He testified that for the last 7 years of his employment with Spartan Printing, he was a supervisor and not allowed to operate the machines. He also testified that he also worked for Spartan Light Metals for approximately 14 years prior to his current employment and that he worked on an assembly line using various machines. He testified that he had no complaints with respect to his upper extremities while he was working for Spartan Light Metals. He testified that he never treated with a physician for bilateral carpal or cubital tunnel syndrome until his current employer, and he also testified that he had never been diagnosed with bilateral carpal or cubital tunnel syndrome until the claim herein.

Petitioner testified that at the time of injury, his normal shift was from 8:00 a.m. until 4:00 p.m. and that he would receive one half hour for lunch and two 15-minute breaks. He testified that he would actually be working on the floor for 7 hours of his shift. He testified that approximately 5-6 hours of his shift would be spent doing some type of hand gripping. He testified that he would also be using and fixing his wrist in a flexed position for the majority of his shift.

Petitioner testified that on January 5, 2016, he was hand-stuffing envelopes which consisted of 8.5x11 magazines going into a 9x12 envelope. He testified that he would then take a glue stick to seal the envelope and place them in the mail tray. He testified that at break, he noticed his hands were going to sleep and that he was having trouble keeping them functioning. He testified that he had these types of sensations before, but never this severe. He testified that his fingers were going numb and that he would drop things following January 5, 2016. At the time of arbitration, he reported that his complaints were much more severe.

The transcript of the deposition of Dr. Nathan Mall was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Mall testified that he is board-certified in orthopedic surgery and is a board-certified independent medical examiner. (PX1).

Dr. Mall testified that he first saw Petitioner on March 20, 2017, at which time he noted bilateral upper extremity numbness, tingling and pain that began sometime in 2015, that it became worse in 2016 and that he noted that it was bothering him during various activities at work. He testified that Petitioner reported that he was a bindery worker at Southern Illinois University, that he had been working there since August of 2011 and that he described his job duties as loading paper into binding machines, fanning the papers out, sliding the papers into the machine, shuffling the materials as they came out and using a cutter. He testified that the job duties appeared to require a substantial amount of gripping, turning, twisting, pushing and pulling-type movements with Petitioner's hands. He testified that based on the history, the physical exam and the diagnostic exams, the diagnosis was that of bilateral carpal and cubital tunnel syndrome. He testified that the nerve conduction study that Petitioner had undergone demonstrated carpal tunnel syndrome, but that cubital tunnel syndrome did not show up on the study which was fairly common. He testified that Petitioner was given an elbow brace to see if that would help resolve some of his cubital tunnel syndrome symptoms. He testified that he did not place Petitioner under any restrictions. (PX1).

Dr. Mall testified that he next saw Petitioner on April 25, 2017, at which time nothing about his diagnosis changed. He testified that at one point he had ordered physical therapy and that it gave Petitioner some mild improvement, but that he was still having the numbness and tingling as well as the discomfort in the wrists and hands as well as the elbows when working and at night. (PX1).

Dr. Mall testified that Petitioner had some osteoarthritis in his DIP and PIP joints in his fingers and that these were fairly far away from the carpal tunnel. He testified that one of the reasons why osteoarthritis could be a risk factor for carpal tunnel was that if there was substantial arthritis at the wrist level, it would narrow the carpal tunnel a little bit further. He testified that in Petitioner's situation his osteoarthritis was not at the wrist level and was more so in the fingers, and that he did not feel that his osteoarthritis in the hand was a major contributing factor to the development of his carpal tunnel syndrome symptoms. He testified that given the fact that Petitioner had substantial job duties that required repetitive gripping,

grasping, turning and twisting of his hands, those factors would be at least a factor in the development of carpal tunnel and cubital tunnel symptoms regardless of his osteoarthritis. (PX1).

Dr. Mall testified that he has prescribed splints and that Petitioner had also completed a course of physical therapy which he recommended. He testified that Petitioner's symptoms have not permanently resolved. He testified that Petitioner did not report to him that he had ever been diagnosed with carpal or cubital tunnel prior to the work-related incident. (PX1).

Dr. Mall testified that his diagnosis was that of carpal and cubital tunnel syndrome, which were considered clinical diagnoses. He testified that one did not need EMG/nerve conduction studies to make those diagnoses. He testified that he believed that Petitioner's work-related activities might or could have been a causative factor in the development of his carpal and cubital tunnel condition. He testified that Petitioner was not diabetic, that he did not have hypertension and that the location of his osteoarthritis was more in the hand rather than the wrist, and that he felt that Petitioner's job activities were probably the major factor in causing the development of carpal and cubital tunnel symptoms. He testified that Petitioner had failed conservative treatment, so he therefore recommended carpal and cubital tunnel releases. (PX1).

On cross examination, Dr. Mall agreed that Petitioner came to him with a prior nerve conduction study and that he did not cause additional studies to be taken. He testified that the one Petitioner already had had shown that he had carpal tunnel syndrome, and that cubital tunnel syndrome was typically not seen on nerve conduction studies until the nerve was actually fairly badly damaged. He testified that if patients had classic signs and symptoms of carpal and cubital tunnel syndrome, nerve conduction studies were not necessary. (PX1).

On cross examination, Dr. Mall testified that the nerve conduction studies that he reviewed showed carpal tunnel syndrome but did not show anything at the cubital tunnel level. He testified that the x-rays that he took showed osteoarthritis at the DIP and PIP joints in the hand, but that there was not any substantial CMC joint arthritis or radiocarpal arthritis. He testified that he was aware of Petitioner's previous surgery at his elbow, that the incision was on the lateral aspect of the elbow and that he assumed it was for lateral epicondylitis. (PX1).

On cross examination, Dr. Mall testified that Petitioner told him that he first began experiencing symptoms in 2015 and that it was basically numbness and tingling in all fingers as well as pain at the wrist level. He testified that Petitioner reported that the left side was worse than the right. He testified that Petitioner reported to him that he experienced symptoms with working and sleeping, and that he also reported that working and sleeping increased his symptoms. (PX1).

On cross examination, Dr. Mall testified that he first saw Petitioner on March 20, 2017 and that he last saw him on April 25, 2017, for approximately one month of treatment. He testified that when he last saw Petitioner, he was still having numbness and tingling as well as discomfort in the wrists and hands as well as in the elbows when working as well as at night. He testified that he reached a diagnosis for Petitioner on March 20th. He testified that he diagnosed cubital tunnel syndrome based on the fact that Petitioner had positive flexion compression testing at the elbow and positive Tinel's at the elbow. He testified that Petitioner had complaints that afforded a diagnosis of cubital tunnel syndrome, including numbness into his little and ring finger. (PX1).

On cross examination when asked why he felt that Petitioner needed to have all of those releases done when it seemed that his symptomatology was not all that great specifically at the elbow, Dr. Mall responded that the right elbow was probably the least affected and that his concern was that if the carpal tunnels were released and Petitioner continued to have numbness in the little and ring fingers, they would have to go back and "do that all over again." He testified that if Petitioner stated that he wanted to try the elbow brace even longer he thought that this was reasonable, but that if he was not noticing a lot of

difference then it was probably not going to make a big difference for him. He testified that one month of conservative care was a standard period of time. (PX1).

On cross examination, Dr. Mall agreed that Petitioner indicated that he started working for Respondent in August of 2011 and that before that, he had a labor position. He testified that Petitioner indicated that he previously polished dyes and drove a forklift. He testified that he did not know how long Petitioner worked for his previous employer. He testified that he reviewed a written job description for Respondent via the IME that was performed by Dr. Sudekum. He testified that he also had in-person discussions with Petitioner about his duties as well. When asked if he discussed with Petitioner whether his duties were always the same or changed, Dr. Mall responded that Petitioner indicated that they changed and that some days he would be doing more shuffling and that some days he would be doing more binding and cutting. He testified that the activities did not necessarily have to be the same activity as long as they were "sort of" repetitive use of his hands or forceful gripping or grasping of his hands. He testified that he did not believe that Petitioner used any vibratory tools. He testified that Petitioner indicated to him that he did not have any significant hobbies. (PX1).

On cross examination, Dr. Mall testified that as to comorbid factors, Petitioner's age was a little bit higher but that he did not think that the amount that that played a role in the development of his carpal tunnel syndrome or cubital tunnel syndrome would surpass the odds of Petitioner having it based on his job duties. He testified that Petitioner was overweight, but not obese. He testified that the arthritis was the only other medical condition that he would consider for Petitioner that could play a role with his condition, but that it was not even really in the right area of the body. (PX1).

On cross examination, Dr. Mall testified that he was previously with Regeneration Orthopedics and that he did not have any reason to dispute that he actually first saw Petitioner on April 12, 2016 through that group. He testified that the history that he took from Petitioner was very similar, that he had numbness in his ring, long and index fingers and that he had numbness and tingling at night, when driving and when working. He testified that they went through the various activities for a bindery worker, that handwritten bindery worker job duties were provided and that his examination and assessment were similar. (PX1).

On further cross examination, Dr. Mall testified that after the April 12, 2016 visit, he next saw Petitioner in March of 2017 and that he did not have any communication with him in the interim timeframe. He testified that when he first saw Petitioner on April 12, 2016, he recommended both the carpal and cubital tunnel releases. (PX1).

The medical records of Chester Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on February 1, 2016, at which time it was noted that he continued to have paresthesias of the hands, especially the left greater than right. It was noted that the EMG and nerve conduction studies confirmed the presence of bilateral carpal tunnel syndrome, worse on the left than the right. It was noted that Petitioner had been wearing a wrist splint on the left hand and that he stated that it may help a little bit during the night, but that he still had the paresthesias. It was noted that Petitioner's current job required repetitive lifting at the wrist and that he was applying for worker's compensation with regard to his current symptoms. Petitioner was recommended to undergo consultation with a surgeon and was advised to go ahead with surgical repair at least of the left side. (PX2).

The medical records of Dr. James Goldring were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent EMG/nerve conduction studies on January 19, 2016, which were interpreted as revealing evidence of bilateral carpal tunnel syndrome with the findings somewhat more pronounced on the left side than the right. (PX3).

The medical records of Auburn Park Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent x-rays of the left hand on April 12, 2016, which were interpreted as revealing interphalangeal joint space narrowing as described; no acute fractures. The Ultrasound/X-Ray History form noted that Petitioner had had left hand numbness and pain for one year. (PX4).

The medical records of NovaCare Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent physical therapy for the timeframe of March 22, 2017 through April 21, 2017. At the time of the Initial Evaluation on March 22, 2017, it was noted that Petitioner reported an onset of symptoms more than one year ago related to frequent use of the hands, wrists and fingers at work. It was noted that Petitioner stated that he had frequent numbness/tingling in his bilateral hands, left greater than right, and that aggravating factors included repetitive gripping, frequent use and repetitive reaching activities. The Discharge Summary dated April 28, 2017 noted that Petitioner was discharged due to a plateau in progress and that he was discontinuing therapy due to insurance visit limitations. (PX5).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The form was completed on January 11, 2016 and noted a date of injury or illness of January 5, 20916. The form noted that Petitioner reported the claim to his supervisor, Blake Mulholland, on January 6, 2016. It was noted that Petitioner alleged that working his normal day-to-day job duties were being performed at the time of injury and that he was loading signatures in booklet makers, hole punching books and loading a paper cutter. It was noted that Petitioner noted that his hands would go numb while performing many of the normal job duties they did every day on different machines. (RX1).

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report noted that the date of accident/incident was that of January 5, 2016 and that the claim was received on January 6, 2016. It was noted that the ongoing work in the shop had allegedly contributed to the wear and tear of Petitioner's hands. It was noted that both of Petitioner's hands were going numb. (RX2).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The IME report of Dr. Anthony Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The transcript of the deposition of Dr. Anthony Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 5. Dr. Sudekum testified that he is a hand and upper extremity specialist who is double board-certified in plastic and reconstructive surgery as well as surgery of the upper extremity. He testified that his specialty is hand and upper extremity surgery and that he has a certificate of added qualification for surgery of the hand. (RX5).

Dr. Sudekum testified that in order to have a diagnosis of carpal tunnel syndrome, one had to have numbness in the little finger because this was the main digit that was innervated by the ulnar nerve. He testified that nerve conduction studies could provide an objective measure of the electrophysiologic qualities of the nerves to see if there was actually any kind of a pathologic process involving the nerve that would be indicative of a condition such as carpal or cubital tunnel syndrome. (RX5).

Dr. Sudekum testified that he performed an Independent Medical Examination on July 21, 2016, that he obtained x-rays of the bilateral hands, wrists and elbows and that he also performed nerve conduction

studies at his office. He testified that the history provided by Petitioner was that he initially presented with symptoms of numbness and tingling in the left hand in the summer of 2015, that he was first evaluated for those symptoms in July of 2015 and that he had been subsequently treated conservatively with wrist splints. He testified that Petitioner reported that in January of 2016, he had undergone nerve conduction studies that had been positive for carpal tunnel syndrome and that there was no evidence of any problem with his ulnar nerve. He testified that Petitioner did not describe any ulnar nerve symptoms to him such as elbow pain or numbness and tingling in the ring or little fingers. He testified that Petitioner indicated that he submitted forms for workers' compensation coverage and was subsequently evaluated by Dr. Mall, who diagnosed him with carpal and cubital tunnel syndrome. He testified that Dr. Mall immediately recommended surgical treatment including staged bilateral carpal and cubital tunnel releases. (RX5).

Dr. Sudekum testified that Petitioner indicated that his current symptoms included primarily symptoms on the left side which were numbness and tingling in the thumb, index, middle and ring fingers, that he indicated that he had had some intermittent and occasional symptoms on the right side, that his symptoms were worse at night and intermittent when driving and that occasionally he would also have symptoms in his hands after working for long periods of time. He testified that Petitioner also described intermittent swelling of his distal forearm and wrist and pain in those areas and that he denied any elbow pain on either side. He testified that Petitioner also indicated that he was unable to fully extend both of his elbows and stated that this had been a problem for him for many years, that he had previously undergone surgical treatment for tennis elbow on the left side and that he still had some problems with extension of both elbows. He testified that he obtained a job description from Petitioner both verbal and written and that the job descriptions were similar in that they covered many of the same tasks and duties. He testified that the clerical tasks were not of a sufficient duration and type in order to "bring about" carpal or cubital tunnel. He testified that he spoke with Petitioner about his employment prior to Respondent and that he reported that he was previously employed by Spartan Light Metal Products for about 14 years where he was a general laborer, where his job involved making dyes for transmission parts, lifting, polishing and removing parts from machines up to 800 parts per day. He testified that Petitioner reported that his job also involved polishing, sanding and etching the parts, which involved manual activities with both hands. (RX5).

Dr. Sudekum testified that his diagnosis was moderate osteoarthritis of both hands and elbows, that Petitioner had tendinitis and osteoarthritis of both elbows with some persistent elbow joint, bony and soft tissue abnormalities and that he felt that Petitioner's loss of elbow motion bilaterally was a result of the bony and soft tissue pathology. He testified that he also felt that Petitioner was experiencing signs and symptoms of intermittent flexor tendinitis of the left distal forearm and wrist, and that Petitioner had no objective evidence of carpal tunnel syndrome or cubital tunnel syndrome at the time that he evaluated him. He testified that he felt that Petitioner's subjective symptoms were due to his osteoarthritis and tendinitis that could be affecting both elbows, the arthritis of the wrists and hands and the flexor tendinitis of the left forearm. He testified that he felt that the left forearm flexor tendinitis may have been aggravated by his current work activities, but that he did not feel that the osteoarthritis of either elbow, the tendinitis of either elbow or the arthritis of either wrist or hand was caused or aggravated by his employment activities. (RX5).

Dr. Sudekum testified that Petitioner had objective findings including the arthritic changes of both hands, wrists and elbows, as well as no evidence of median or ulnar neuropathy. He testified that the Tinel's being positive on both sides was normal, which would be consistent with the negative findings. He testified that the wrist Phalen's was positive on the left which was inconsistent with his finding, which was that the nerve conduction studies showed no evidence of carpal tunnel syndrome. He testified that the provocative tests were subjective and that Petitioner had a flexor tendinitis of the left forearm extending to the wrist, which could cause a similar finding and may have been why Petitioner had a positive Phalen's. (RX5).

Dr. Sudekum testified that he disagreed with Dr. Mall's diagnosis of bilateral carpal tunnel syndrome and cubital tunnel syndrome and that he also disagreed with the treatment. He testified that even if the diagnosis was of those conditions, there was in his opinion no evidence to require surgical treatment

especially for the diagnosis of cubital tunnel syndrome, since Petitioner had no symptoms of cubital tunnel syndrome except under Dr. Mall's provocation. He further testified that Petitioner did not have any numbness of his little finger, which was a required symptom to make the diagnosis of carpal tunnel syndrome. (RX5).

Dr. Sudekum testified that in his review of Petitioner's medical records, at no point was there any evidence of ulnar neuropathy. He testified that the earliest note that he had indicating that Petitioner was complaining of symptoms of peripheral neuropathy was when he was evaluated on July 6, 2015 by Dr. Krieg. He testified that his review of Dr. Goldring's nerve conduction study performed on January 19, 2016 was that Petitioner had borderline findings on the right and that the conduction velocities of all of the nerves were well within the normal ranges. He testified that the left median nerve was mildly elevated and would be consistent with mild carpal tunnel syndrome on the left and what could be considered borderline on the right, but that it was actually in the normal range because it said up to "4.5" was normal. He testified that the study also evaluated the bilateral ulnar nerve and found no evidence of any ulnar neuropathy/cubital tunnel syndrome and that the EMGs were all normal as well. He testified that his studies revealed no evidence of median neuropathy at all and that the conduction velocities were normal for the median and ulnar nerves. He testified that the tests were basically a measure of the health and electrophysiologic parameters of the nerves measured at two different times and that typically they were going to be more consistent when the nerves were measured in relatively short periods of time between studies. He testified that Petitioner's osteoarthritis of the hands and wrists would oftentimes affect the findings as well because of the relative swelling associated with those conditions in close proximity to the nerves being measured. (RX5).

Dr. Sudekum testified that he recommended that Petitioner be evaluated by a rheumatologist for his arthritic conditions affecting the elbows, wrists and hands and that he also be evaluated and treated by a certified occupational therapist for the left forearm flexor tendinitis. He testified that he did not feel that Petitioner was a surgical candidate. He testified that he disagreed with Dr. Mall's surgical recommendation because he did not feel that Petitioner was suffering from those conditions. He testified that it would be extremely aggressive to even suggest cubital tunnel releases on either side and that when he saw Petitioner, there was no objective evidence of carpal tunnel syndrome which would be consistent with a transient carpal tunnel phenomenon that might be associated with his arthritis and/or tendinitis. (RX5).

Dr. Sudekum testified that he thought that the treatment Petitioner had received up until the time that he saw him in July of 2016 was medically necessary and appropriate. He testified that Petitioner had co-morbid factors that could lead to the development of carpal or cubital tunnel down the road, including his age and the diagnoses of osteoarthritis and tendinitis. He testified that he did not feel that Petitioner was at maximum medical improvement when he saw him and that he felt that he was capable of working full duty without restrictions at that time. He testified that he thought that Petitioner's prognosis was good, that it was important to understand that the conditions were chronic and that it was likely that Petitioner would continue to have some symptoms associated with these conditions. (RX5).

On cross examination, Dr. Sudekum testified that he based some of his conclusions on the nerve conduction studies that he performed. When asked what types of conservative treatment he would outline prior to surgery for carpal tunnel syndrome, Dr. Sudekum responded that first and foremost, one had try to figure out what the co-morbid factors and conditions that could be causing the condition were and to treat those. He testified that things like wearing a splint and taking an anti-inflammatory medication would also be very helpful. (RX5).

On cross examination, Dr. Sudekum testified that certain types of activities that could contribute to the development of carpal tunnel syndrome include sustained heavy gripping and grasping, especially with impact and/or vibration. He agreed that he reviewed the job studies attached to his report that he agreed

that Petitioner's job consisted of gross hand manipulation 67-100% of his day, fine hand manipulation 34-66% of the day and that he was pushing and pulling 50 pounds 34-66% of his shift. (RX5).

On cross examination, Dr. Sudekum testified that swelling in the forearm was not caused by carpal tunnel syndrome, but that swelling in the forearm could potentially cause some carpal tunnel symptoms if the swelling was sufficient. When asked if Petitioner's job duties might or could contribute to the development of carpal tunnel syndrome, Dr. Sudekum responded that he felt that it may have contributed to the development of Petitioner's tendinitis and that if he were to develop carpal tunnel syndrome, he would have to evaluate Petitioner and make a determination whether or not he felt that was a condition that might have been related to his job. He testified that when he saw Petitioner, he did not suffer from those conditions and that he did not address the question of causation of carpal tunnel syndrome or cubital tunnel syndrome based on the job duties and the job description. (RX5).

On cross examination, Dr. Sudekum testified that the symptoms Petitioner was suffering from were similar to what someone having carpal tunnel syndrome would report. He testified that assuming it was tendinitis, the job duties as he understood them could aggravate that condition. (RX5).

On redirect, Dr. Sudekum testified that when one had a flexor forearm tendinitis, there could certainly be soreness in the forearm, wrist and hand and that in certain situations if the inflammation were acute and there was significant swelling, one could have some secondary compression of the median nerve as a result of the tendinitis. (RX5).

CONCLUSIONS OF LAW

With respect to disputed issues (C), (E) and (F), given the commonality of facts and evidence relative to these issues, the Arbitrator addresses those simultaneously.

The Arbitrator finds that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on January 5, 2016, that timely notice of the accident was given to Respondent and that his current condition of ill-being of left forearm flexor tendinitis is causally related to his work activities for Respondent, but that his alleged condition of carpal tunnel syndrome and cubital tunnel syndrome is not causally related to the accident.

Having reviewed and considered the evidence as a whole, the Arbitrator finds Dr. Sudekum's causation opinions to be more persuasive than those proffered by Dr. Mall. At the outset, the Arbitrator places significant weight on the opinions of Dr. Sudekum given his position of a hand and upper extremity specialist who is double board-certified in plastic and reconstructive surgery as well as surgery of the upper extremity. (RX5). Furthermore, the Arbitrator finds to be significant Dr. Sudekum's admission on cross examination that the symptoms Petitioner was suffering from were similar to what someone having carpal tunnel syndrome would report and that assuming it was tendinitis, the job duties as he understood them could aggravate that condition. (*Id.*). The Arbitrator notes that Dr. Sudekum also testified on redirect that when one had a flexor forearm tendinitis, there could certainly be soreness in the forearm, wrist and hand and that in certain situations if the inflammation were acute and there was significant swelling, one could have some secondary compression of the median nerve as a result of the tendinitis. (*Id.*). The Arbitrator places significant reliance upon Dr. Sudekum's assertion that it would be extremely aggressive to even suggest cubital tunnel releases on either side given that when he saw Petitioner, there was no objective evidence of carpal tunnel syndrome which would be consistent with a transient carpal tunnel phenomenon that might be associated with his arthritis and/or tendinitis, and the Arbitrator further finds to be significant Dr. Sudekum's testimony that in his review of Petitioner's medical records, at no point was there any evidence of ulnar neuropathy. (*Id.*). In light of the foregoing, the Arbitrator finds that Petitioner's current

condition of ill-being of left forearm flexor tendinitis is causally related to his work activities for Respondent, but that his alleged condition of carpal tunnel syndrome and cubital tunnel syndrome is not causally related to the accident.

As to the issue of notice, the Arbitrator finds, while he may have noticed some symptoms in 2015, the evidence reflects that Petitioner did not reach his breaking point until January 5, 2016 at which time he realized his condition was at its worst and believed that his work could be a contributing factor. The evidence further reflects that the Workers' Compensation Employee's Notice of Injury was completed on January 11, 2016 and noted a date of injury or illness of January 5, 20916 and further noted that Petitioner reported the claim to his supervisor, Blake Mulholland, on January 6, 2016. (RX1). As the claim was timely reported within the 45 days as required under the Act, the Arbitrator finds that timely notice of the accident was given to Respondent.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on January 5, 2016, that timely notice of the accident was given to Respondent and that his current condition of ill-being of left forearm flexor tendinitis is causally related to his work activities for Respondent, but that his alleged condition of carpal tunnel syndrome and cubital tunnel syndrome is not causally related to the accident.

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 his work accident of January 5, 2016. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services as set forth 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 prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Dr. Sudekum, including, but not limited to, the recommended evaluation and treatment by a certified occupational therapist.

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

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Aaron Stewart,
Petitioner,

vs. NO: 13 WC 22855

City of Berwyn,
Respondent.

18IWCC0292

DECISION AND OPINION ON REVIEW

Not timely Petition for Review having been filed by the respondent herein regarding the propriety of the claim's reinstatement following its dismissal for want of prosecution, and notice given to all parties, the Commission, being advised of the facts and law, addresses the jurisdictional issue raised by the claimant as a necessary prerequisite to any discussion regarding the merits of the reviewed issues.

As background, the respondent's review disputes, first, whether Arbitrator Glaub had jurisdiction to enter a reinstatement order on January 31, 2017, following the dismissal for want of prosecution (DWP) which had been entered on June 20, 2016, and, second, whether such a reinstatement was warranted under the facts and circumstances of the case.

The Commission must address the argument raised by the petitioner on review, which is that the Commission lacks jurisdiction in regards to the instant appeal. It is not disputed that the parties were apprised of Arbitrator Glaub's ruling on January 31, 2017, the date of the hearing on the petition to reinstate. Based on that date, the last day to timely file for Commission review of the decision would be thirty days later, or March 2, 2017. The respondent filed its review on March 3, 2017.

18IWCC0292

The Commission notes, as an aside, that in the claimant's dispute as to jurisdiction, he rather uncharitably characterizes the respondent's missing of the review deadline as evincing a lack of diligence, and he does so without apparent irony or self-reflection given the circumstances of the original DWP order and the arising of this issue. Having so noted, the claimant is fortunate that this issue does not rely on equitable principles in its determination.

The Commission finds that the Arbitrator's reinstatement order became final on March 2, 2017, and the respondent's review is therefore dismissed for lack of jurisdiction. In accordance with the above finding, it is unnecessary to address the merits of the respondent's case. This matter is hereby remanded to the Arbitrator for further proceedings in accordance with this order.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 31, 2017, granting reinstatement of this case is affirmed for the reasons stated above, and that this matter is remanded to the Arbitrator for further consideration.

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: MAY 8 - 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-03/21/18
jdl/ac
68

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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WALTER LASETER,

Petitioner,

vs. NO: 12 WC 24486

ILLINOIS DEPARTMENT OF CORRECTIONS,

Respondent.

18IWCC0293

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 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.

For the reasons stated below, the Commission hereby vacates the wage differential award under Section 8(d)1 of the Act, and awards Petitioner 40% loss of use of the person as whole under Section 8(d)2 of the Act.

On the date of accident, May 25, 2012, Petitioner was 47 years old, and worked as a corrections lieutenant for Respondent. As a result of the May 25, 2012 accident, Petitioner underwent a right elbow open distal biceps repair, left shoulder arthroscopy with intra-articular debridement, type 1 SLAP lesion and biceps tenotomy, a subacromial decompression with acromioplasty, rotator cuff repair, a mini open subpectoral biceps tenodesis, and a right carpal

tunnel release.

Following an arbitration hearing on June 5, 2017, the Arbitrator awarded Petitioner weekly wage differential benefits commencing June 6, 2017, and continuing, until the date Petitioner turned 67 years old. As a basis for her Decision, the Arbitrator noted that Petitioner's main impediment to returning to his former occupation as a corrections officer was his inability to use a handgun, indicating that this was "an essential part of his job duties as a corrections officer." The Arbitrator further explained,

> The subjective nature of Petitioner's concerns in using a handgun as well as the results from both FCE exams, are not lost on the Arbitrator. However, the Arbitrator notes that Dr. Wysocki deferred to Petitioner's discretion on his ability to return to his job safely. The Arbitrator notes that Petitioner's concerns about returning to his job as a corrections officer and accepting a position in security are legitimate and logical given the nature and safety concerns posed by those jobs. (Arbitrator's Decision, pg. 8).

The Arbitrator then calculated the wage differential amount using the average earnings of a customer service representative, receptionist, and central scheduler, which was approximately $16.00 per hour. By his brief, Petitioner agreed with the Arbitrator's award and wage differential calculation of $414.42 per week. Respondent, on the other hand, argued that Petitioner could have secured employment within the security field as early as 2013, and that his limitations are "largely self-imposed." (Respondent's Brief, pg. 14). By its brief, Respondent stated,

> Petitioner was told about many positions in the security field that would not require him to restrain individuals or carry a weapon. Yet, Petitioner chose not to focus on getting a job in security claiming that he "can't do that job anymore" and that the "physical restraints on that job is what got [him] in this position now." (Respondent's Brief, pg. 15).

Respondent also claimed that Petitioner's treating doctor deferred to Petitioner as to whether he could do his job, and that Petitioner had not established that he was medically unable to perform his regular duties. Further, Respondent indicated that Petitioner was hindering his own vocational effort by searching for jobs in areas in which he had no experience in. Therefore, Respondent requested that this Commission award benefits under Section 8(d)2 of the Act, and not a wage differential award under Section 8(d)1 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

18IWCC0293

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.

According to the record, Petitioner's treating physician, Dr. Robert Wysocki, considered the October 30, 2015 functional capacity evaluation (FCE) in order to render his opinion on whether Petitioner required work restrictions. Dr. Wysocki released Petitioner to full duty after examining him on November 6, 2015 and finding Petitioner neurologically intact and with no biologic or physiological abnormalities that would necessitate permanent work restrictions. He also could not recommend any restrictions based on the October 30, 2015 FCE which classified Petitioner's performance and effort as inconsistent and unacceptable.

Notwithstanding Dr. Wysocki's opinion, Petitioner explained his "inconsistent performance":

> Well, with my injury, if you ask me to do something, I can do it at a hundred percent. But then if you ask me to do that same effort size or thing again, I can't do it. So I need time to recover in order to do it. If I'm asked to do something else, like my lifting restriction is 20 pounds. If you asked me to lift 30, I can lift 30. If you ask me to do it again, I can't do it because of the numbness and the pain. (T.27).

The Commission finds Petitioner's explanation reasonable, and in light of the other two FCE's that Petitioner completed, which were deemed valid, the studies were similar. For example, the September 10, 2013 FCE demonstrated that Petitioner performed at the medium physical demand level and as such, met the physical requirements of his job as a corrections lieutenant. However, Petitioner had issues with gripping and lifting to shoulder and overhead heights; these factors could be of critical importance when restraining inmates. The final FCE on December 3, 2015 again determined that Petitioner could work in the medium physical demand level and was capable of working as a correctional lieutenant. However, the FCE report stated that Petitioner's limitations and pain reports related to his right upper extremity could compromise his ability to fire a weapon and engage in self-defense which is required by his job. Respondent's Section 12 examiner, Dr.

Paul Papierski, also agreed that Petitioner could not return to his normal work, but provided a different reason – that Petitioner had been off work for a significant time.

In considering the record thus far, there is sufficient evidence to support a finding that Petitioner is partially incapacitated from pursuing his usual and customary line of employment as a correctional lieutenant; as of the date of arbitration, Petitioner was engaged in vocational rehabilitation, was receiving maintenance, and there was no indication that Respondent had offered any type of employment to Petitioner.

The principal issue here turns on the second prong of a wage differential claim – whether Petitioner suffered an impairment in the wages he earns or is able to earn; the Commission finds that Petitioner failed to prove his entitlement to a wage differential award under this second prong. The evidence as it stands now is insufficient to determine whether suitable employment, in which Petitioner is both able and qualified to perform, is available; and, if such employment is available, whether the employment would result in an impairment of earnings; and, if such impairment exists, there is insufficient evidence to properly calculate the wage differential award. *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 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.

As stated above, Petitioner has not provided sufficient evidence for the Commission to identify an occupation that Petitioner is able and qualified to perform, and the average wage for that occupation. Instead, the record demonstrates that the vocational counselor, Kari Stafseth, had prepared a Labor Market Survey, which identified several potential jobs for Petitioner as a customer representative, security supervisor, security guard, and merchant patroller. Some of the jobs had no salary information, and others offered hourly wages from $9.00 to $18.00 per hour. The Arbitrator also considered the parties' joint exhibit 1, the records from Vocamotive, which identified other potential work as a receptionist or central scheduler earning about $16.00 per hour. Petitioner himself spent approximately six months contacting 650 employers for work in various fields. The last vocational progress report prior to arbitration is dated May 28, 2017 and demonstrated Petitioner's ongoing job search and upcoming goals.

With this said, although evidence of potential jobs was offered at arbitration by Petitioner, the Commission finds that this evidence does not demonstrate an occupation that Petitioner is able and qualified to perform, and the average wage for that occupation; the Commission cannot consider a range of jobs across a variety of occupations with variable wages; more importantly the Commission will not consider speculative evidence. *United Airlines, Inc. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (1st) 121136WC ¶17, ¶29.

In further consideration, the Commission notes that the parties had stipulated to Petitioner's average weekly wage (AWW) at the time of the injury which was $1,261.63. However, there was no testimony or other evidence concerning the current wage rate for Petitioner's job (i.e., the amount he would be earning in his old job had he not sustained the work injury); this is an essential part of the wage differential equation. The Vocamotive records also indicated that Petitioner reported earning $96,000 per year with Respondent, but this does not coincide with what the parties stipulated to at arbitration. In any event, the Arbitrator used Petitioner's AWW of $1,261.63 and an average of wages from the potential jobs identified in Vocamotive's records to calculate the wage differential award. Unfortunately, under *Crittenden*, this is not the correct method; 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 may then apply that number to the current average weekly wage for Petitioner's job (i.e., the amount he would be earning in his old job had he not sustained the work injury), and complete the wage differential calculation.

Based on the above, the Commission finds that Petitioner did not meet his burden of proof for a wage differential award under Section 8(d)1 of the Act. Thus, as Petitioner failed to prove a loss in earning capacity, the Commission finds that the proper award would be an award under Section 8(d)2 of the Act. Therefore, the Commission awards Petitioner 40% loss of use of the

person as whole, taking into consideration the following five factors listed under Section 8.1(b) of the Act:

(i) Impairment Rating: No weight should be given to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: Given the above analysis relative to the Commission's finding that Petitioner is partially incapacitated from pursuing his usual and customary line of employment as a correctional lieutenant, the Commission gives significant weight to this factor.

(iii) Petitioner's Age: Petitioner was 47 years old on the accident date; noting that Petitioner may have to contend with his disability for an extended period, the Commission gives some weight to this factor.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: As a result of the May 25, 2012 work-related accident, Petitioner suffered a right elbow distal biceps rupture, left shoulder pain, impingement, and rotator cuff tear, and right carpal tunnel syndrome. Petitioner underwent a right elbow open distal biceps repair, left shoulder arthroscopy with intra-articular debridement, type 1 SLAP lesion and biceps tenotomy, a subacromial decompression with acromioplasty, rotator cuff repair, a mini open subpectoral biceps tenodesis, and a right carpal tunnel release.

By November 14, 2014, Petitioner was still complaining of numbness, tingling, stiffness, and pain in his right hand, and Dr. Wysocki indicated that Petitioner had persistent median nerve injury in the forearm. Petitioner's treating surgeon, Dr. Nikhil Verma, evaluated Petitioner on December 8, 2014, and recommended surgery to release the medial nerve through the pronator teres. Petitioner elected not to have surgery because it was an exploratory procedure with a 50/50 percent chance of success. As of December 8, 2014, Dr. Verma stated that Petitioner could work light duty with a 20-pound lifting/pushing/pulling restriction and no weapon use. Further, and as discussed above, two valid FCEs and Respondent's Section 12 examiner, Dr. Paul Papierski, reported that Petitioner would have difficulty returning to his normal duties as a correctional lieutenant. The Commission gives significant weight to this factor.

Based on the totality of the evidence, the Commission awards Petitioner 40% loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed July 17, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

18IWCC0293

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 pay to Petitioner the sum of $756.98 per week for a period of 200 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 40% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related injuries pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, including credit under Section 8(j), if any, and shall hold Petitioner harmless for same.

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

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

DATED: MAY 8 - 2018
MJB/pm
O: 04-03-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LASETER, WALTER
Employee/Petitioner

Case# **12WC024486**

12WC024485

IL DEPT OF CORRECTIONS
Employer/Respondent

18IWCC0293

On 7/17/2017, 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 1.12% 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:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60603

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT 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

JUL 17 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Walter Laseter
Employee/Petitioner

v.

IL Dept. of Corrections
Employer/Respondent

Case # 12 WC 24486

Consolidated cases: 12 WC 24485

18IWCC0293

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **6/5/17**. 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. xx Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☒ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **5/25/17**, 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 **$65,605.00**; the average weekly wage was **$1,261.63**.

On the date of accident, Petitioner was **47** years of age, *single* 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 **$129,648.00** for TTD, **$0** for TPD, **$46,560.40** for maintenance, and **$0** for other benefits, for a total credit of **$176,208.40**.

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

ORDER

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS, COMMENCING 6/6/17, OF $414.42 PER 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.

RESPONDENT SHALL PAY PETITIONER THE REASONABLE AND NECESSARY MEDICAL EXPENSES INCURRED IN THE CARE AND TREATMENT OF HIS CAUSALLY RELATED INJURIES PURSUANT TO SECTIONS 8 AND 8.2 OF THE ACT. RESPONDENT SHALL RECEIVE CREDIT FOR AMOUNTS PAID, INCLUDING CREDIT UNDER SECTION 8(J) IF ANY, AND SHALL HOLD PETITIONER HARMLESS FOR SAME.

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

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

Carolyn M. Oneely

Signature of Arbitrator

7/14/17
Date

JUL 17 2017

FINDINGS OF FACT

Petitioner was employed as a corrections lieutenant with the respondent on May 25, 2012. His duties included supervision of the sergeants and officers as well as direct control and physical contact with inmates. As he testified, he would be called any time there was a problem. Accident is not in dispute. ARB EX 2. On May 25, 2012, Petitioner was called to the visiting room to address a situation wherein an inmate had argued with and assaulted his girlfriend. Petitioner testified that he arrived in the room and told the inmate he was to be cuffed and placed under arrest. Petitioner testified that he was then violently attacked by the inmate and while trying to restrain the inmate, Petitioner felt immediate pain in his right arm in the bicep area and in the area of his left shoulder.

Petitioner was seen at Proven St. Joseph Medical Center on 5/25/12. The records indicate complaints of severe right arm pain. PX 9. He was diagnosed with right bicep muscle tendon tear. PX 9.

He sought orthopedic consult after the accident. On June 5, 2012, Dr. Verma performed a right elbow distal biceps repair. The surgical report indicates complaints of acute onset of antecubital elbow pain following a work-related injury. (Px. 10) Dr. Verma discussed evidence of a partial high-grade injury to the right distal biceps and recommended open repair. (Px. 10) Dr. Verma noted "At the same time, he was having symptoms with regard to the left shoulder and his clinical examination was consistent with impingement and we recommended and injection." (Px. 10) Dr. Verma proceeded with surgery—right elbow open distal biceps repair and with a left shoulder subacromial cortisone injection. (Px. 10)

Post-surgery and injection, petitioner reported numbness, pain and tingling in the medial aspect of the right forearm and minimal relief in the left shoulder. (Px. 1) On 6/18/12, Petitioner again reported that his continued left shoulder pain was related to his initial injury at work. PX 1. Dr. Verma placed petitioner in occupational and physical therapy. (Px. 1,2)

As petitioner's left shoulder symptoms persisted, Dr. Verma recommended and performed surgical intervention on November 16, 2012—arthroscopic subacromial decompression with acromioplasty, intra-articular debridement of a type 1 SLAP lesion and biceps tenotomy, rotator cuff repair, and mini open subpectoral biceps tenodesis. (Px. 10) The operative report indicates that Petitioner reported a history of a work related injury and failed conservative care for the left shoulder complaints. PX 10.

Post-surgery, on November 26, 2012, petitioner exhibited pain in the right arm and left shoulder and was kept off-work. (Px. 1) Petitioner continued treatment with Dr. Verma through early 2013. As of March 6, 2013, he had pain in the anterior aspect of the left shoulder and was making slow progress. (Px. 1) He was to remain off of work per Dr. Verma.

On April 24, 2013, Dr. Verma evaluated the bilateral upper extremities. (Px. 1) He continued physical therapy for both upper extremities and administered a left shoulder injection. (Px. 1) On June 5, 2013, petitioner reported occasional soreness and numbness in the right elbow and end range stiffness in the left shoulder. (Px. 1) Petitioner was placed in work conditioning for 4 weeks with consideration of a functional capacity evaluation thereafter. (Px. 1)

With petitioner having ongoing right hand numbness and tingling, Dr. Verma recommended an EMG for the right arm on July 10, 2013. He also recommended a left shoulder MRI given persistent left shoulder pain. The MRI, reviewed by Dr. Verma August 21, 2013, showed a healing tendon with no recurrent defect in the left shoulder. (Px. 1). He noted the right arm EMG showed some slowing of median nerve as it crosses the pronator

muscle. He advised Petitioner it was unclear as to whether further surgical intervention would make a substantial difference in his current function level. He recommended an FCE to determine the level of function and then told Petitioner to return to see him to discuss the FCE results and recommendations. PX 1.

On September 16, 2013, Dr. Verma noted that Petitioner returned following completion of the FCE for his right upper extremity symptoms and the left shoulder pain. No further treatment was recommended for Petitioner's left shoulder despite continued pain complaints for which Dr. Verma recommended Tylenol. With regard to the right median nerve symptoms, Dr. Verma noted Petitioner's report that he had difficulty gripping his gun at work. He noted additional work conditioning was recommended and that Petitioner was to return following the work conditioning for reevaluation. Dr. Verma also sent Petitioner to Dr. Wysocki, a hand specialist, for the median nerve symptoms and potential operative care.

Petitioner met with Dr. Wysocki on October 18, 2013 and described right arm pain radiating into his palm. (Px. 1) The petitioner described the pain waking him at night and needing to shake his hand out. (Px. 1) Dr. Wysocki suspected carpal tunnel syndrome. He recommended an injection and night splinting. (Px. 1)

Petitioner returned to Dr. Verma on October 23, 2013. (Px. 1) At that time, Dr. Verma reviewed recent work conditioning reports which indicated petitioner "had the ability to perform his occupation with the exception of requalifying with his handgun secondary to right hand numbness. The patient is frustrated that he continues to have a nagging pain in the left shoulder and right elbow. ... at this point his clinical exam is unchanged with essentially near full range of motion with the exception of 5 degrees of external rotation and terminal elevation. ... unfortunately there is no further treatment option that we can offer. He has undergone extensive conservative care including anti inflammatories, activity modifications, therapy work condition and injection as well as surgical intervention. At this point, I do feel that he is at maximum medical improvement and would defer any further treatment to Dr. Wysocki in regard to this right hand. From my perspective, he would be able to return t work with the exception of qualification with a handgun pending further evaluation of his right hand. ..." (Px. 1) Petitioner was discharged from the care of Dr. Verma at that time.

On November 1, 2013, petitioner described to Dr. Wysocki ongoing numbness and tingling in the right fingers. (Px. 1) He stated the feeling would extend to the whole hand. (Px. 1) Dr. Wysocki recommend a right wrist splint and carpal tunnel injection. (Px. 1) He administered the injection on that date and restricted petitioner from use of a weapon as a work restriction. (Px. 1)

Upon the next evaluation, on December 20, 2013, Dr. Wysocki noted minimal relief since the injection. He noted that the numbness continued in the index and long finger of the right hand. (Px. 1) He discussed carpal tunnel release and the surgery was preliminary scheduled for the next month. (Px. 1) In the interim, Dr. Wysocki opined petitioner could return to work light duty with no use of a weapon. (Px. 1)

On February 6, 2014, Dr. Vender performed a Section 12 examination at the respondent's request. (Px. 3) Dr. Vender noted continued numbness following the 2012 right biceps repair. (Px. 3) His diagnosis was status post distal biceps tendon repair, probable right carpal tunnel syndrome and degenerative arthritis of the right wrist. He causally related the elbow and hand complaints, including the carpal tunnel, but found no causal connection for the right wrist complaints. He noted that Petitioner had reached MMI for the right elbow but not for the carpal tunnel. He determined that Petitioner did not need any work restrictions with regard to his right elbow and that carpal tunnel did not necessitate work restrictions and that he was able to return to his previous work activities. he found that petitioner did not require physical restrictions and could return to his previous work duties. (Px. 3)

When petitioner returned to Dr. Wysocki on March 28, 2014, he noted worsening right median innervated digits and right elbow pain. He was told to see Dr. Verma regarding the right elbow. Right carpal tunnel surgery was set for and proceeded May 29, 2014. (Px. 1, Px. 10)

Following the right carpal tunnel release, petitioner followed up with Dr. Wysocki on June 13, 2014. (Px. 1) Petitioner's numbness in the right hand, thumb and index finger and arm was unchanged (Px. 1) Dr. Wysocki initiated a 5 lbs. lifting, pushing and pulling restriction. (Px. 1) With no change in petitioner's status on July 25, 2014, Dr. Wysocki recommended work conditioning and a light duty 15 pound lifting restriction at work. Petitioner was to return in 2 weeks for additional EMG and assessment if his symptoms continued. (Px. 1)

As of September 5, 2014, petitioner still had no improvement in the right hand numbness and tingling. (Px. 1) Dr. Wysocki ordered a new EMG to compare to the prior EMG. (Px. 1) Dr. Wysocki reviewed the EMG on November 14, 2014 and noted persistent right median nerve injury in the proximal forearm distal to the pronator teres. No further pinching of the median nerve at the wrist was noted on EMG. He referred petitioner back to Dr. Verma to address issues possibly related to the biceps repair in 2012. (Px. 1). He was released to work with a 20 pound restriction and no use of a weapon.

Dr. Verma evaluated the petitioner on December 8, 2014 and noted numbness over the anterolateral forearm with some radiation from the elbow proximally. (Px. 1) He discussed a final option of pronator teres release of the median nerve. (Px. 1) He referred petitioner back to Dr. Wysocki for this procedure.

On January 16, 2015, Dr. Wysocki reviewed the EMG with petitioner and noted no persistent signs of carpal tunnel syndrome but ongoing involvement at the proximal forearm. (Px. 1) Dr. Wysocki stated that although pronator syndrome or median nerve involvement from a distal biceps repair was relatively rare, it could account for petitioner's ongoing symptoms. (Px. 1) He posited a surgical intervention of median nerve decompression but could not predict success. (Px. 1) He stated that the benefits of the surgery may outweigh the risks. He placed a 20 lbs. lifting restriction at that time and no use of a weapon. (Px. 1)

Petitioner sought a second opinion with Dr. Carroll on May 1, 2015. (Px. 7) Dr. Carroll diagnosed right upper extremity neuropathy and left shoulder impingement. (Px. 7) On June 2, 2015, petitioner underwent diagnostic testing at Matteson MRI—EMG and an MRI of the left shoulder. The former indicated evidence of localized right median sensori-motor neuropathy from the elbow distally to wrist/fingers. (Px. 4) The MRI of the left shoulder was normal (Px. 4) On July 16, 2015 petitioner presented to Dr. Carroll with ongoing right elbow pain. He had continued numbness and tingling from the elbow to the hand with grip weakness. (Px. 4) He discussed median nerve surgery at the elbow.

Petitioner returned to Dr. Wysocki on August 14, 2015 who Dr. Carroll's statements regarding the exploratory nature of the surgery and the alternative of an FCE to determine permanent restrictions. Dr. Wysocki noted Petitioner's continued symptoms of numbness and tingling in his thumb, index, and long finger mostly that radiate up the forearm and then occasionally further up towards the shoulder. The majority of the pain was localized to the anterior aspect of his elbow near the area of his biceps surgical incision. Petitioner chose the FCE. (Px. 1)

The FCE took place at Athletico on October 30, 2015. (RX 5) Inconsistent performance and unacceptable effort were noted and it was noted that Petitioner could perform 80% of his job demands. The evaluator noted that Petitioner was capable of greater functional ability than demonstrated during the FCE. At trial, petitioner was asked about his FCE performance. He testified that he was able to do most activities on the first attempt but then would experience numbness and tingling which would prevent a second attempt. Pain behaviors were noted

during the weapon firing simulation. He testified that the proctor of the evaluation did not seem to understand this. RX 5.

Following the FCE, petitioner returned for a final visit with Dr. Wysocki on 11/6/15. (Px. 1) The doctor noted that exploratory surgery with decompression of the right median nerve in the proximal forearm was still an option. (Px. 1) He could not predict significant gains from further surgery. (Px. 1) With petitioner declining surgery, Dr. Wysocki placed petitioner at maximum medical improvement for his right hand and wrist and deferred to Dr. Verma on the elbow but noted that no further treatment had been rendered. (Px. 1) With perceived inconsistent FCE performance, Dr. Wysocki declined to definitively state petitioner's restrictions. (Px. 1). He noted that based on the objective findings he could not conclude on a discrete permanent work restriction. He further noted Petitioner was neurologically intact on exam and that he did not see an absolute biologic or physiological reason why a certain permanent work restriction is necessary. The functional capacity evaluation was also unable to determine such a level. I told him that in situation such as this, especially since he was able to meet the vast majority of his work demands despite the inconsistent performance and unacceptable effort, the most prudent step is to authorize him for a return to work full duty without restrictions." He told Petitioner it was up to his discretion as to whether he could safely perform the job of a corrections officer based on his subjective complaints which Dr. Wysocki could not objectively support. (Px. 1)

Petitioner underwent a second FCE on December 3, 2015. (Px. 5) This FCE found that petitioner gave a consistent and valid effort. It was noted that petitioner's limitations and pain reports in his right hand and arm would compromise his ability to handle a weapon as well as engage in self-defense. (Px. 5) Otherwise, Petitioner demonstrated the ability to return to his prior job. PX 5.

Dr. Papierski performed a Section 12 examination at respondent's request on January 27, 2016. (Px. 6) The doctor noted petitioner's complaints of pain and paresthesia of the right elbow and forearm with milder pain in the left shoulder with stiffness. (Px. 6) The doctor found that petitioner's behavior was appropriate and that there was a causal relationship between the distal biceps tendon repair as well as subsequent carpal tunnel syndrome. (Px. 6) He further noted his opinion that the left shoulder "was likely associated with age and general activity." He found that treatment to that point had been reasonable and necessary for the right elbow injury. (Px. 6) He agreed that additional treatment was a consideration including median nerve decompression starting in the elbow going to the proximal right forearm. He opined that if petitioner declined median nerve exploration then he would be at MMI. He further stated that "the prognosis is overall generally good from a medical standpoint. From a psychosocial standpoint, this individual has been off of work for an extended period of time and at age 50, the statistics indicate that it is not highly likely that he will return to his normal work." (Px. 6)

Respondent subsequently authorized vocational rehabilitation with Vocamotive. (Joint Ex. 1) Petitioner underwent an initial interview with Kari Stafseth, CRC. (Jx. 1) Subsequently, Stafseth issued an Initial Evaluation Report on June 3, 2016. (Jx. 1) It was noted that petitioner was 50 years old and had graduated from Julian High School in Chicago in 1983. (Jx. 1) He served in the United States Marines from 1984 to 1988. (Jx. 1) He earned an honorable discharge with the rank of Lieutenant. (Jx. 1) He attended Olive Harvey College seeking a criminal justice degree but did not obtain his Associate's Degree. (Jx. 1) In 1989, he began working as a correctional officer with the respondent. (Jx. 1) His duties entailed providing security, maintaining control of the facility and inmates, and other post activities. (Jx. 1)

Stafseth determined that petitioner had lost access to his usual and customary line of occupation as a corrections lieutenant, citing the opinion of Dr. Papierski. (Jx. 1) She did find that petitioner was employable in the projected jobs of customer service representative, security supervisor, security guard, and loss prevention

officer. (Jx. 1) She also found that petitioner could consider positions of front desk clerk, cashier, dispatcher and similar positions. (Jx. 1) She performed a labor market survey within these position fields. (Jx. 1) She determined that petitioner would likely have a probable earning potential of $9.00 to $12.00 per hour on the lower end and $13.00 to $16.00 per hour on the higher end. (Jx. 1) Thereafter, petitioner began vocational rehabilitation. (Jx. 1)

He was placed in training for Windows 7, Word Basic, Excel Basic and Keyboarding. For the former three, he earned passing grades. For the latter, he failed. (Jx. 1) Vocamotive referred petitioner to James Boyd for vocational evaluation on October 4, 2016. (Jx. 1) Mr. Boyd evaluated petitioner's skill set at that point and determined he should pursue occupations such as management trainee, security manager, surveillance system manager, information clerk, bailiff, security consultant , probation officer, truant officer, intake worker, security guard, gate guard, and social service aide. (Jx. 1)

Petitioner was thereafter engaged in a job search. (Jx. 1) An overview of the vocational rehabilitation records indicates that petitioner was engaged in a job search through June 2017. During that time he participated in interviews, mock interviews, in-person applications, online applications. (Jx. 1) He was hesitant to return to security or other jobs which could require use of physicality with another person. (Jx. 1) He testified that he generally was directed to apply for jobs with a starting hourly rate of $10-11/hour. The most recent Vocamotive reports of April 25, 2017 and May 28, 2017 show petitioner being directed for jobs in customer service, receptionist, central scheduler. In the week of March 31 to April 6, petitioner made 49 contacts. In May, he pursued positions in loss prevention, security manager, shipping and receiving clerk, patient services representative and guest service advisor. At trial, Petitioner testified that he wants to work. He agreed that he can and will find a job in customer service.

Petitioner further testified that after he was taken off work in May 2012 he has received service pay, extended benefits, TTD and maintenance benefits through his job search and up to the date of trial.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

F. Is Petitioner's current condition of ill-being causally related to his work accident?

Petitioner provided unrebutted testimony that at the time of injury he was 47 years old, married with one dependent child. Based on the overwhelming medical evidence from the treating and examining physicians, the Arbitrator finds Petitioner's conditions in his right arm and hand including the biceps and the carpal tunnel are causally related to the accident of May 25, 2012. The Arbitrator further finds that Petitioner's left shoulder condition is also causally related to the accident of May 25, 2012, as supported by the initial treating records of Dr. Verma, the chain of events and the severity of the altercation at work logically supporting a left shoulder injury.

J. Were the medical services provided to the Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the causally

related conditions in Petitioner's right hand, arm and left shoulder pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

K. Are any TTD benefits due?

Petitioner testified at trial that he was paid Service Connected leave in the days immediately after the accident on May 25, 2012 and that he then received Extended Benefits until he was placed on TTD benefits. Petitioner then received maintenance benefits after he started vocational rehabilitation and had been continuously paid benefits up to the date of trial. (See Rx 6) Therefore, no TTD or other temporary benefits are due or owing in this case. Respondent shall receive a credit for all amounts paid. ARB EX 2.

L. What is the Nature and Extent of the Petitioner's Injury?

Petitioner contends that he is entitled to wage loss benefits under Section 8(d)1 of the Act. Respondent contends that petitioner should receive his PPD under Section 8(e) of the Act for disability to his right arm and to his right hand. Based on a preponderance of the credible evidence at trial and specifically the evidence to support a wage differential, the Arbitrator finds that Petitioner is entitled to benefits under Section 8(d)(1) of the Act. In so finding, the Arbitrator notes that Petitioner's main impediment to returning to his former occupation as a corrections officer is his inability to use a handgun, an essential part of his job duties as a corrections officer. The subjective nature of Petitioner's concerns in using a handgun as well as the results from both FCE exams. are not lost on the Arbitrator. However, the Arbitrator notes that Dr. Wysocki deferred to Petitioner's discretion on his ability to return to his job safely. The Arbitrator notes that Petitioner's concerns about returning to his job as a corrections officer and accepting a position in security are legitimate and logical given the nature and safety concerns posed by those jobs. Thus, the Arbitrator finds that as a result of Petitioner's right arm and hand injuries, Petitioner has become partially incapacitated from pursuing his usual and customary line of employment.

The most recent Vocamotive reports of April 25, 2017 and May 28, 2017 show petitioner being directed for jobs in customer service, receptionist, and central scheduler earning up to $16.00 per hour. The Arbitrator finds work in these fields to be suitable. Accordingly, the Arbitrator finds that petitioner's average wage in the identified fields of work would be $16.00 per hour or $640.00 per week. Considering his average weekly wage at the time of injury, $1,261.63, this creates a weekly wage loss of $414.42.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeronimo H. Garcia,

Petitioner,

vs. NO: 13 WC 8460

UPS Freight,

18IWCC0294

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the 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.

The Commission finds Petitioner sustained significant permanent disabilities as a result of the November 30, 2012, work accident. Petitioner sustained serious injuries after falling off the back of his delivery truck onto the ground. Petitioner hit his head on the ground and injured his cervical spine, left shoulder, and left wrist. Petitioner also sustained a facial laceration that required 11 sutures. Petitioner's surgeon, Dr. Smith, diagnosed central cord syndrome and mid-subaxial stenosis. Dr. Smith also noted that cervical stenosis is a risk for someone trying to return to work as a truck driver. Notably, Dr. Smith stated, "if [Petitioner] had not been employed as a truck driver and did not desire to return to work, we would likely not feel that surgery would be appropriate." (PX 4 at 5-6). Dr. Smith performed a posterior cervical decompression and fusion on January 23, 2013. The surgery consisted of a C4-C5 laminectomy, partial C3 and partial C6 laminectomy, C4-C6 posterior spinal instrumentation with lateral mass screw fixation, and C3-C6 posterior lateral fusion and arthrodesis.

The work accident also exacerbated Petitioner's left rotator cuff tendinopathy and AC joint arthritis. Dr. Saltzman treated Petitioner's shoulder injury conservatively with physical therapy and a corticosteroid injection into the left AC joint. Petitioner also sustained an injury to his left wrist. Dr. Nagle diagnosed osteoarthritis at the first CMC joint, diffuse osteopenia, and a questionable avulsion fracture.

18IWCC0294

Petitioner returned to work without restriction in September 2013 and has continued to work full duty since his return. However, Petitioner testified that he still suffers from significant cervical pain and numbness whenever he turns his head while driving the truck. He also complained of ongoing pain in his left shoulder and some fingers on his left hand. Petitioner testified he now has a bump on his left wrist. Petitioner testified that his ability to move, carry things, and turn his neck were all affected by the work accident. He testified that he has trouble sleeping because certain positions aggravate his neck. Petitioner also testified that he is considering retiring soon in part because of his ongoing pain relating to this work accident.

The Commission finds Petitioner testified credibly regarding his treatment relating to the work accident and his related ongoing complaints. After considering the totality of the evidence, including Petitioner's testimony, the severity of Petitioner's cervical injury, his left shoulder injury, and Petitioner's ongoing difficulties affecting his ability to perform his job and other daily activities, the Commission finds the Arbitrator's award of 20% loss of use of the whole person does not properly account for the clear evidence of Petitioner's permanent disability as a result of his cervical and left shoulder injuries. Instead, the Commission finds Petitioner suffered a 27.5% loss of use of the whole person.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 3, 2016, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner permanent partial disability benefits of $712.55 for 147.75 weeks, because Petitioner's injuries caused 27.5% loss of use of the whole person and 5% loss of use of the left hand, as provided for in §§8(d)2 and 8(e) of the Act.

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

IT IS FURTHER ORDERED that Respondent pay to Petitioner interest pursuant to §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: MAY 8 - 2018

o: 3/20/18
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

18IWCC0294

DISSENT

I respectfully dissent from the decision of the majority. I would affirm and adopt the Arbitrator's findings. I particularly find the award be well reasoned, persuasive and grounded in the record. I would affirm the decision in its entirety.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, JERONIMO H
Employee/Petitioner

Case# **13WC008460**

UPS FREIGHT
Employer/Respondent

18IWCC0294

On 2/3/2016, 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 0.46% 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:

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
JACOB R SCHNEIDER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

JERONIMO H. GARCIA
Employee/Petitioner
v.
U.P.S. FREIGHT
Employer/Respondent

Case # 13 WC 8460
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 **12/16/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11-30-12**, 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 **$65,050.44**; the average weekly wage was **$1,250.97**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$35,861.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$35,861.14**.

ORDER

Medical benefits
Respondent shall pay to Petitioner $192.08 for the outstanding bill from AthletiCo, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $833.98 per week for 42 4/7 weeks, commencing 12/01/12 through 8/23/13, as provided in Section 8(b) of the Act. Respondent shall be granted a credit in the amount of $35,861.14 for TTD payments previously made.

Nature and Extent of Disability
Respondent shall pay Petitioner permanent partial disability benefits of $712.55 for 110.25 weeks, because the injuries sustained caused 20% loss of use man as a whole and 5% loss of use of the left hand, as provided for in Section 8(d)2 and 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.

FINDINGS OF FACTS

18IWCC0294

Petitioner's testimony

Jeronimo Garcia, ("Petitioner"), testified that on November 30, 2012, he was employed by UPS Freight ("Respondent") as a delivery truck driver. He is right-handed and had been employed by Respondent since September 3, 1997.

His job duties involved picking up and delivering packages to various locations in the Chicago area. Approximately one to two times per month he had to lift packages weighing up to 20 pounds and occasionally up to 50 pounds.

On November 30, 2012, he was making a delivery at a bookstore. He was closing the back gate of his truck and slipped and fell. His shoe got caught on the loop handle used to close the truck door. He fell on his right side with his left arm behind him. He struck the right side of his head on the concrete deck. Afterwards, he had bleeding over his right eye, his left shoulder and wrist were painful and his neck felt heavy with numbness and pain. He was taken by UPS personnel to Concentra Medical Center where his left wrist was placed in a splint, a cervical collar was applied and he was transferred by ambulance to Christ Hospital.

At Christ Hospital, he was further examined and underwent CT and MRI scans of his neck. He was discharged in a hard cervical collar and his left wrist in a splint. He was referred to Parkview Orthopedic Group where he was seen on December 6, 2012, by Dr. Anis Mekhail for his neck; and Dr. Nirav Shah for his left hand. He was taken off work and his left arm was placed in a Spica cast.

He next sought care at Northwestern Memorial Hospital, where he saw Dr. Zachary Smith, a neurosurgeon. Dr. Smith examined him and recommended that he have surgery on his neck. He underwent surgery on January 3, 2013, at Northwestern Memorial Hospital. Post surgery, he was prescribed physical therapy at AthletiCo and was discharged from Dr. Smith's care on September 23, 2013.

After the accident he also noticed left shoulder pain. He was seen by Dr. Matthew Saltzman for problems with his left shoulder. The doctor recommended an MRI scan and physical therapy, which he performed at AthletiCo. His last visit with Dr. Saltzman was on May 2, 2013 and he was given an injection at that time.

He also sought treatment with Dr. Daniel Nagle for problems with his left wrist. Dr. Nagle took x-rays and prescribed home exercises. He last saw Dr. Nagle on April 9, 2013.

He returned to his regular job as a deliver driver after September 23, 2013. He currently notices pain and numbness with difficulty moving his neck. He also has left shoulder pain and pain in his left wrist, which keeps him awake at night. He had none of these problems before the accident of November 30, 2012.

Petitioner's medical treatment

Petitioner's Exhibit 1 is records from Concentra, which show that Petitioner treated from November 30, 2012 to December 30, 2012. The initial history indicates that his shoelace got stuck on a cargo door rope and he tripped and fell to the right side, breaking the fall with his arms and right hip and striking the right side of his face on the ground, resulting in a laceration. He was found to have mild positional left-sided neck discomfort, a scraped right shin, a laceration superior to the right eyebrow, some positional pain in the right and left wrists, some tenderness of the cervical spine at the end of the range of motion, mild edema of the left wrist with pain and a superficial abrasion to the right anterior tibia. He was diagnosed with neck pain, instability was ruled out; a facial laceration, which was sutured; a contusion to the orbital tissues; a left wrist evulsion fracture, with pain; an abrasion to the right lower leg; and a contusion to the right hip. He was transferred to Christ Hospital Emergency Room in a hard collar and a Spica splint on his left wrist. He returned to Concentra on December 3, 2012 where he was diagnosed with a scalp laceration and cervicalgia. He was advised to continue using the cervical collar and return for removal of the stitches.

Petitioner's Exhibit 2 is records from Christ Hospital Emergency room. The petitioner was seen on November 30, 2012 and a history was taken that he was a 62-year-old, otherwise healthy male, presenting from urgent care clinic after tripping over loading bay door cord at work, falling four feet and striking the front of his head, without loss of consciousness. He was complaining of neck pain and had a five centimeter laceration on the right forehead. X-rays revealed a C4 compression fracture with spondylolisthesis. The diagnosis was a cervical compression fracture, a left wrist fracture and forehead laceration. A CT scan was performed which showed minimal disc height at C4-C5, most likely degenerative in nature. X-rays of the left wrist showed an equivocal, triquetral fracture fragment along the dorsum of the proximal carpal radius. An MRI of the cervical spine demonstrated minimal grade one anterolisthesis of C4 and C5. Moderate to marked cervical spine degenerative disease was noted.

Petitioner's Exhibit 3 is records of Parkview Orthopedic Group where the petitioner was seen on December 6, 2012, by Dr. Anis O. Mekhail, for cervical complaints. It was noted he had neck pain with no radicular symptoms. The history states, the condition started on November 30, 2012 when he fell and tripped in his job as a truck driver. X-rays revealed C4-C5 anterolisthesis which moves with flexion/extension about 4 to 5

millimeters. Dr. Mekhail felt the MRI showed significant stenosis at C4-C5 and C5-C6, with moderate stenosis at C3-C4. A disc protrusion was noted at C5-C6 with bone spurs and significant facet degeneration. The diagnosis was C4-C5 anterolisthesis with significant stenosis from C3 through C6, with a positive Hoffman's sign, for instability. Dr. Mekhail recommended a C3 to C6 anterior cervical decompression and fusion.

At Parkview Orthopedics the petitioner also saw Dr. Nirav A. Shah for pain complaints of his right knee and left wrist. Dr. Shah recorded a history that on November 30, 2012, the petitioner's foot got caught in a lift gate and that he has pain in his right knee and left wrist. X-rays showed no obvious fractures or dislocations. He was diagnosed with a right proximal tibia contusion. He was placed in a short arm Spica cast and was taken off work and advised to have an MRI scan of the left wrist. PX3.

Petitioner elected to receive treatment at Northwestern Memorial Hospital and physicians at Northwestern Medical Faculty Foundation. He came under the care of Dr. Zachary Smith, a neurosurgeon; from December 10, 2012 to September 15, 2014.

The history taken by Dr. Smith indicates the petitioner complained of significant pain in the cervical spine and numbness in both feet and at times, tingling in his arms. It was noted the patient stated he fell off a truck while making deliveries at work and that he hit his head, which caused him to hyperextend his neck. The doctor's physical examination included findings of a positive Hoffman's reflex.

The doctor reviewed the MRI film of the cervical spine and felt it was consistent with mild cervical stenosis at C4-C5 and to a lesser extent at C6. He noted mild disc bulges and flattening of the cervical cord at C4-C5 and C5-C6. The diagnosis was central cord syndrome, with mild sub axial cervical stenosis. The doctor recommended a fusion after the CT scan and MRI films were repeated. The CT scan on December 14, 2012 demonstrated multi-level degenerative disc changes with stenosis, at C3 through C6.

On January 3, 2013, Dr. Smith performed a C4 to C5 laminectomy and partial laminectomies at C3 and C6 with a C4 through C6 posterior spinal fusion and instrumentation and lateral mass screw fixation. The postoperative diagnosis was cervical degenerative disc disease, cervical stenosis and central cord syndrome.

The petitioner returned to Dr. Smith on February 4, 2013 and was noted to have complaints of difficulty with coordination of his hands and loss of balance. The doctor recommended physical therapy which the petitioner initially attended from February 12, 2013 to May 20, 2013. Upon discharge, Petitioner was noted to have ability to manipulate 25 pounds at an occasional level. On April 8, 2013, the doctor felt the

petitioner needed three more months in a cervical collar. On July 1, 2013, the doctor noted a post-surgical CT scan demonstrated new bony fusion and good alignment. An MRI scan showed good decompression of the stenosis. The doctor recommended Petitioner discontinue use of the cervical collar and recommended another course of physical therapy.

The petitioner attended physical therapy at AthletiCo from July 10, 2013 to September 5, 2013. Upon discharge he demonstrated continued range of motion deficits with rotation of the cervical spine; and the goal of manipulating 50 pounds, at an occasional level, was not met.

The petitioner saw Dr. Smith on September 23, 2013, when the doctor noted that he was doing well and cleared him to return to work as a truck driver. The petitioner last saw Dr. Smith on September 15, 2014, who noted that Petitioner's strength was 5/5 in the bilateral upper extremities. X-rays demonstrated no movement of the hardware and with a good postural lateral fusion. Dr. Smith released the petitioner from his care at that point.

The petitioner sought treatment with Dr. Matthew Saltzman also of Northwestern Medical Faculty Foundation for his left shoulder complaints. He was under the care of Dr. Saltzman from February 26, 2013 to May 2, 2013. In the initial history Dr. Saltzman noted Petitioner came in for evaluation of the left shoulder and that on November 30, 2012 he was working for UPS when he fell off the back of a truck and has had persistent left shoulder pain ever since the injury.

Petitioner reported normal shoulder function prior to the injury and the doctor noted positive Neer and Hawkins signs for impingement. The doctor noted painful elevation to 160 degrees and recommended an MRI scan. The petitioner returned on March 14, 2013, when Dr. Saltzman noticed weakness of the supraspinatus. An MRI was performed which demonstrated rotator cuff tendonitis and subacromial bursitis, with changes of the acromioclavicular joint. The doctor's diagnosis was rotator cuff tendonitis, most likely present before the injury, which may have been exacerbated by his work. The doctor recommended physical therapy and that Petitioner should avoid repetitive overhead duties with no pushing, pulling or lifting over 10 pounds. The petitioner last saw Dr. Saltzman on May 2, 2013; who still noted mild weakness of the supraspinatus, with positive impingement signs. External rotation was 10 degrees less than the opposite side. The diagnosis was tendinopathy with acromioclavicular joint arthritis. The doctor indicated that he should continue with home therapy and performed an injection of the left shoulder. PX5.

For his left wrist condition, Petitioner treated with Dr. Daniel Nagle, from February 27, 2013 to April 9, 2013, who is also with Northwestern Medical Faculty Foundation. At the initial visit, the petitioner provided the doctor a history of left wrist pain which is worse with extension, that began immediately after the fall. The doctor reviewed x-rays which showed no evidence of fracture or dislocation. He found the petitioner's range of motion was somewhat decreased and placed the petitioner in a volar wrist splint, giving him instructions regarding range of motion home exercises. He felt the petitioner should not return to work until there was a better understanding of the diagnosis. At that time he diagnosed diffuse osteopenia, osteoarthritis of the first CMC joint, irregularity along the radial styloid which may represent a fracture and some question of an avulsion fracture.

On March 14, 2013, the doctor noted the petitioner's range of motion of the wrist was somewhat decreased, so he should work on his range of motion and strengthening, which he could do with home exercises. On April 9, 2013, the doctor felt that Petitioner could use his wrist in a non-restricted fashion and released the petitioner from his care.

Among the exhibits offered by the respondent was a report from Dr. Robert A. Beatty dated September 20, 2013. His diagnosis was degenerative cervical spondylosis pre-existing the November 30, 2012 injury that exacerbated the cervical symptoms without any radicular component, producing a soft tissue injury and mild symptoms. He felt the surgery was related to the pre-existing changes. He performed an impairment rating and found that the petitioner had a zero percent impairment. He found no documented instability. RX4.

Respondent had the petitioner's records reviewed by Dr. Martin Herman, who offered a report dated January 12, 2015. Dr. Herman diagnosed pre-existing cervical spondylosis due to degenerative disease and cervicalgia exacerbated by a workplace accident. The doctor felt the petitioner's cervical fusion was for treatment of a pre-existing structural abnormality, which was not related to his treatment of the workplace accident. He felt the petitioner would have reached maximum medical improvement ("MMI") for neck pain related to the workplace accident, at the latest six months after the alleged injury, which would have been on May 30, 2013. He felt the petitioner did not sustain any hearing loss from a cervical injury. He noted that at the initial Concentra evaluation on November 30, 2013, the petitioner did not exhibit dizziness, vertigo, blood or fluid in the nose or ears. At that time, the petitioner had normal external auditory canals clear and normal tympanic membrane. RX5.

18IWCC0294

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).

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).

The Arbitrator finds that a causal connection exists between the condition of ill-being of the petitioner's cervical spine, left arm and left wrist and the accident of November 30, 2012. This conclusion is based, in part upon, the testimony of Petitioner, regarding the mechanism of injury. He was taken by the Respondent's safety personnel to a Concentra Occupational Medicine clinic, where they placed him in a cervical collar, splinted his left wrist and transferred him to Advocate Christ Medical Center. At the hospital they took x-rays of his neck, left arm and right knee. They also performed a CT and MRI scan of the cervical spine. Also, Petitioner testified that he had no neck, left arm or wrist pain before the accident of November 30, 2012.

The Arbitrator notes that the petitioner's testimony and the medical records describe an accident which is a sufficient mechanism for aggravation of pre-existing degenerative disc disease and which could cause injuries to the left wrist and shoulder. The Arbitrator further notes that in the treating medical records, the petitioner consistently attributes the onset of his neck, left arm and left wrist symptoms to the fall at work. The petitioner ultimately was diagnosed with cervical degenerative disc disease, cervical stenosis and central cord syndrome. Consequently on January 3, 2013, he underwent a

fusion at C3 to C6, with laminectomies. On December 10, 2012, Dr. Zachary Smith commented: "This is a 62 year old male who appears to have had a mild cervical cord like event after a fall from a truck in setting of severe cervical stenosis at C3 to C5."

The record demonstrates that the petitioner had pre-existing degenerative changes of the cervical spine, which were asymptomatic and were aggravated by the fall of November 30, 2012; necessitating surgical intervention. Immediately after the fall, x-rays demonstrated a C4-C5 anterolisthesis. The petitioner had documented complaints of neck pain at Concentra and was transferred by ambulance to Christ Hospital in a neck brace. The record indicates that the petitioner has consistently complained of neck pain since the accident of November 30, 2012, with an inability to return to work for over nine months.

Proof of good health and change immediately following and continuing after an injury may establish that the impaired condition was due to the injury. A causal connection between work duties and the condition may be established by a chain of events including the petitioner's ability to perform duties before the date of the accident and inabilities to perform the same duties following that date. *Navistar International Transportation Corporation vs. The Industrial Commission*, 734 NE 2d 900, 906, 315 Ill.App.3d 1197 (2000).

A claimant need prove only that some act or phase of his employment was a causative factor in the ensuing injury. A work-related injury need not be the sole or principal causative factor as long as it was a causative factor in the resulting condition of ill-being. *Vogel vs. Industrial Commission*, 812 NE 2d 807, 354 Ill.App.3d 780 (2005).

The petitioner went from a pain free state where he was capable of working every day to a state of persistent pain, with hyperreflexia and a positive Hoffman's sign and over nine months of total disability, immediately after the fall at work. These are compelling facts that demonstrate an aggravation occurred to the cervical spine causing the petitioner's previously asymptomatic condition to become symptomatic leading to the surgery and his resulting condition of ill-being.

The petitioner was also diagnosed with a left rotator cuff tendinosis. According to his credible and unrebutted testimony, his left shoulder pain started after the fall at work. He indicated to Dr. Matthew Saltzman on February 26, 2013, that he had persistent left shoulder pains since falling off the back of a truck. He reported normal shoulder function prior to the injury. Dr. Saltzman ordered an MRI which demonstrated rotator cuff tendinosis. The doctor commented, "This was most likely present before his injury. It may have been exacerbated by his work." Based upon the above, the Arbitrator

concludes that the accident of November 30, 2012 was a causative factor of the petitioner's left shoulder condition.

Regarding the left wrist, the petitioner immediately reported left wrist pain at Concentra and was placed in a left wrist thumb Spica splint. He received follow-up care from Dr. Shah, who diagnosed a pretibial bone bruise. He then saw Dr. Daniel Nagle who felt that Petitioner had osteoarthritis of the first CMC joint, a possible fracture of the radial styloid and a questionable avulsion fracture of the left wrist. The left wrist pain was solely attributed to the accident at work on November 30, 2012. Consequently, the Arbitrator finds the condition of ill-being of the left wrist is work-related.

The petitioner also testified to the loss of hearing in the left ear since his surgery. There is no opinion that attributes the hearing loss as a post-surgical complication. The petitioner saw Dr. David B. Conley for this condition on August 28, 2013. Dr. Conley is also with Northwestern Medical Faculty Foundation. The petitioner reported decreased hearing in his left ear after a motor vehicle accident a year prior. Dr. Conley's examination of the left ear was normal. The petitioner then saw Dr. Alan Micco also of Northwestern Medical Faculty Foundation.

On October 15, 2013, the petitioner reported to Dr. Micco that his hearing loss began when he fell off the back of a UPS truck at work. Dr. Micco noted the audiogram showed an asymmetric hearing loss, but he found no abnormalities of the ears. He concluded the petitioner had an asymmetric hearing loss most likely post traumatic. There is no record of hearing complaints by the petitioner until August 23, 2013, to Dr. Conley. There is no history of a hearing loss immediately following the accident. Consequently, the Arbitrator finds that insufficient proof exists that Petitioner's hearing loss, in the left ear, was caused by the accident of November 30, 2012.

K. What temporary benefits are in dispute? (TTD)

The Arbitrator finds that the petitioner was temporarily and totally disabled for 42 and 4/7ths weeks from December 1, 2012 through September 23, 2013.

This conclusion is based, in part, upon the testimony of the petitioner that after his fall on November 30, 2012 he remained off work until after September 23, 2013, when he was released to return to work by Dr. Zachary Smith, his treating neurosurgeon.

The petitioner was initially seen at Concentra after the accident on November 30, 2012, and December 3, 2012. He was placed on restrictions of limited use of the arms, and he was found unable to drive a company vehicle.

He was next seen by Dr. Anis Mekhail at Parkview Orthopedics on December 6, 2012, who felt he had severe stenosis and needed a fusion and would be off work for six weeks to three months. The petitioner also saw Dr. Nirav Shah who diagnosed a tibia contusion and prescribed an MRI scan of the left wrist. He indicated the petitioner should be off work at that visit.

On December 10, 2012, the petitioner came under the care of Dr. Zachary Smith of Northwestern Medical Faculty Foundation, who recommended a fusion that was performed on January 3, 2013. The petitioner subsequently underwent two courses of physical therapy and was not cleared by the doctor to return to work as a truck driver until September 23, 2013.

The petitioner was also under the care of Dr. Martin Saltzman, for left shoulder pain. On March 14, 2013, Dr. Saltzman indicated that the petitioner had rotator cuff tendinosis and he recommended physical therapy with avoidance of aggravating activities. He thought the petitioner would be able to return to full duty, relative to the shoulder, in six to twelve weeks. On May 2, 2014, he felt the petitioner could return to work for his shoulder condition.

The above listed evidence indicates that the petitioner was unable to return to his usual and customary employment as a truck driver, was under active medical care and had not reached MMI during the period in dispute.

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

The Arbitrator finds that the petitioner sustained injuries to his cervical spine and left shoulder that resulted in permanent partial disability to the whole person with additional permanent partial disability to the left hand. This conclusion is based, in part, upon the testimony of the petitioner that he currently notices neck pain, with a

sensation of heaviness and numbness in his neck. Because of the pain he has difficulty sleeping. He also has difficulty turning his neck to the side. He also notices a bump on his left wrist and has pain in that wrist and his left shoulder pain.

On January 3, 2013, the petitioner underwent a C4 through C5 laminectomy, partial laminectomies at C3 and C6 with a posterior lateral fusion with arthrodesis, spinal instrumentation and lateral mass screw fixation, performed by Dr. Zachary Smith. The postoperative diagnosis was cervical degenerative disc disease, cervical stenosis and central cord syndrome. Post-surgically, the doctor noted that Petitioner had difficulty with co-ordination of his hands and balance. Dr. Smith prescribed physical therapy for two sessions. The last session the petitioner attended at AthletiCo was from July 10, 2013 to September 5, 2013. The AthletiCo discharge note indicates that he continued to have range of motion deficits, with rotation of the cervical spine. The petitioner's goal of being able to manipulate 50 pounds, on occasion, was not met upon discharge from therapy.
On September 23, 2013, Dr. Smith released him to return to work as a truck driver at UPS. The petitioner last saw Dr. Smith on September 15, 2014. Dr. Smith noted his balance and co-ordination have continued to improve. The petitioner complained of 40% loss of hearing at that time. The x-ray demonstrated no movement of the hardware and good posterior lateral fusion. Dr. Smith felt the petitioner had a good recovery from the surgery.

The petitioner was treated for the left shoulder by Dr. Matthew Saltzman of Northwestern Medical Faculty Foundation. On February 20, 2013, the doctor noted that the petitioner has positive impingement signs with painful elevation to 160 degrees.

On March 14, 2013, the doctor noted weakness of the supraspinatus. An MRI taken on that date indicates the petitioner had rotator cuff tendinosis and subacromial bursitis, with some changes of the acromioclavicular joint. The doctor felt these changes existed previous to the accident at work, but were exacerbated by it. Dr. Saltzman prescribed physical therapy.

On May 2, 2013, Dr. Saltzman indicates that the petitioner reported great improvement of range of motion and strength with physical therapy and that the petitioner was doing a home exercise program. The petitioner had 4/5 weakness in the supraspinatus and continued to have positive impingement signs, with the pain localized in the acromioclavicular joint. Range of motion had improved with 150 degrees forward flexion, 90 degrees abduction and external rotation was 10 degrees less than the right side. The petitioner could internally rotate his shoulder to L3. He was given an

injection of Kenalog and Lidocaine and was released from the doctor's care with instructions to return to activity, as tolerated.

Regarding the left hand, the petitioner initially complained of left wrist pain at Concentra, on the day of the accident. On December 6, 2012, he saw Dr. Nirav Shah for right knee and left wrist pain. X-rays showed no obvious fractures or dislocations. The petitioner was diagnosed with a pretibial bone bruise. He received no follow up care for his right leg complaints and there were no further complaints of right leg pain problems in the medical records. Therefore, the Arbitrator concludes no permanent partial disability exists in the right leg.

The petitioner did follow-up with Dr. Daniel Nagle at Northwestern Medical Faculty Foundation for the left wrist. Dr. Nagel saw the petitioner on February 27, 2013, who diagnosed diffuse osteopenia, osteoarthritis of the first CMC joint, irregularity along the radial styloid that may have represented a fracture, with a questionable avulsion fracture that was not evident on the film. The doctor prescribed a wrist splint, range of motion exercises and no work until there was a better understanding of the diagnosis.

On March 14, 2013, the doctor found the range of motion was somewhat decreased. On April 9, 2013, he released the petitioner with no restrictions for the wrist. He found no tenderness, but the range of motion of the wrist was found to be, "Somewhat decreased."

With regards to subsection (i) of Section 8.1b(b), the Arbitrator notes the record contains an AMA rating of zero percent, as determined by Dr. Robert Beatty, pursuant to the most current edition of the American Medical Association's guidelines. 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 no objective findings. Because of the significant nature of the cervical procedure for the cervical spine and objective findings relative to the left shoulder and wrist, the Arbitrator gives lesser weight to this factor.

With regards to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that the petitioner was employed as a delivery driver at the time of the accident and that he was able to return to work in his prior capacity after the injury. The Arbitrator notes that the petitioner currently complains of neck pain and difficulty turning his neck from side to side, along with shoulder and wrist pain. Because of the importance of upper body movement in the petitioner's ability to perform his job duties, the Arbitrator gives greater weight to this factor.

With regards to subsection (iii) of Section 8.1b(b), the Arbitrator notes that the petitioner was 62-years-old at the time of the accident and on the down side of his working career. The Arbitrator gives some weight to this factor.

With regards to subsection (iv) of Section 8.1b(b), the petitioner's future earnings capacity, the Arbitrator notes that the petitioner has returned to his regular job duties and he is currently making more money than he was before the accident however, the petitioner testified that his mobility has decreased and his knee hurts when he drives the truck. Consequently the Arbitrator gives a little weight to this factor.

With regards to subsection (v) of Section 8.1b(b), evidence of disability covered by the medical records, the Arbitrator notes that The petitioner had a significant surgical procedure performed to his cervical spine including a fusion from C3 to C6, objective evidence of tendinosis by MRI scan of his left shoulder with positive impingement signs and x-ray changes in his left wrist. Because of these significant objective findings, the Arbitrator gives greater weight to this factor.

Based on the above factors and the record taking as a whole, the Arbitrator finds that the petitioner sustained permanent partial disability to the extent of a 20% loss of use of the whole person pursuant to Section 8(d-2) of the Workers' Compensation Act regarding his cervical and left shoulder injuries. The Arbitrator further finds that the petitioner sustained a 5% loss of use of the left hand as a result of his left wrist injury.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC08460
SIGNATURE PAGE

18IWCC0294

Signature of Arbitrator

February 3, 2016
Date of Decision

FEB 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 LAKE)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Justin O'Neil,

Petitioner,

vs. NO: 16 WC 31519

JGS Marine LLC, d/b/a Mastercraft Boats,

18IWCC0295

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, prospective medical treatment 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. 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 notes that §19(l) of the Act provides, in pertinent part, that "[i]n case the employer or his or her insurance carrier shall without good or just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b) the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay."

§19(k) of the Act provides, in pertinent part, that "[i]n 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 this 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."

Finally, §16 of the Act provides, in pertinent part, that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier … 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."

Based on the above, and pursuant to the dictates of *Hollywood Casino-Aurora, Inc. v. Workers' Compensation Commission*, 967 N.E.2d 848, 359 Ill.Dec. 818 (2nd Dist. 2012), the Commission modifies the decision of the Arbitrator to find that the Commission lacks the authority to award penalties based on a failure or delay in authorizing medical treatment. Along these lines, the court in *Hollywood Casino-Aurora, Inc.*, supra, specifically noted that even "[a]ssuming for the sake of analysis that this provision (§8[a]) is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance[] of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving that authorization." *Hollywood Casino-Aurora*, 967 N.E.2d at 852. And while the case specifically dealt with a Commission award under §19(k), the Commission finds that by extension the same rationale would apply to penalties pursuant to §19(l) and §16 as well. In support of its holding, the appellate court pointed out that "[t]he statute addresses 'delay in payment' and 'underpayment' of compensation. It says nothing about any award of additional compensation (penalties) for an employer's delay in authorizing medical treatment, even assuming *arguendo* that an employer has an obligation to give authorization in advance of medical treatment for an injured employee." *Hollywood Casino-Aurora*, 967 N.E.2d at 851.

Furthermore, per the statute, §16 attorney fees are predicated on an award pursuant §19(k), and since *Hollywood Casino-Aurora, Inc.*, supra, has determined that §19(k) does not authorize the Commission to award penalties for the failure to authorize medical treatment it follows that §16 attorney fees are likewise not available under such circumstances.

Therefore, while the Commission does not condone the actions of Respondent in denying authorization for surgery that both the Arbitrator and the Commission on Review believe to be reasonable and necessary as well as causally related, the plain language of the statute, as explained by the appellate court in *Hollywood Casino-Aurora, Inc.*, supra, simply does not provide for the award of penalties based upon a failure or delay in authorizing treatment. As a result, the Commission hereby vacates the Arbitrator's award of additional compensation pursuant to §19(l) and attorneys' fees pursuant to §16 of the Act.

All else is otherwise affirmed and adopted.

18IWCC0295

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 6/16/17 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment prescribed by Dr. Roger Chams, including but not limited to arthroscopic surgery of the right knee, open removal of the patellar bursa and further treatment related to post-surgical rehabilitation of the right knee pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of additional compensation as provided in §19(l) and attorneys' fees as provided in §16 of the Act, is hereby vacated.

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 $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 8 - 2018
o:4/3/18
TJT/pmo
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT 18IWCC0295

I dissent. Respondent's conduct in first approving and then revoking its authorization for surgery based on such a flimsy excuse as evidenced here is both unreasonable and vexatious and worthy of the imposition of penalties if there ever was cause for such an award. And if the Act does not allow for the imposition of such penalties, as the majority holds, then the statute can and should be amended to punish the type of reprehensible behavior demonstrated in this case.

The majority cites *Hollywood Casino-Aurora, Inc. v. Workers' Compensation Commission*, 967 N.E.2d 848, 359 Ill.Dec. 818 (2nd Dist. 2012) in support of its decision to vacate the Arbitrator's award of additional compensation pursuant to §19(l) and attorneys' fees under §16 of the Act. *Hollywood Casino-Aurora, Inc.*, supra, stands for the proposition that the Act does not specifically grant the Commission the authority to award ***§19(k) penalties*** based on a failure or delay in authorizing medical treatment given that "[t]he statute addresses 'delay in payment' and 'underpayment' of compensation." The appellate court was ***not*** asked and did ***not*** comment on the appropriateness of ***§19(l)*** and ***§16*** penalties for the failure to authorize same.

It should be noted that there was a time in Illinois when employers and their insurance carriers could refuse to timely pay, with impunity, medical bills that had not yet been awarded by the Commission. The excuse was that such penalties were not contemplated by the Act. All of that changed in 1998 with the decision in *McMahan v. Industrial Commission*, 183 Ill.2d 499, 702 N.E.2d 545, 234 Ill.Dec. 205 (1998), wherein the Illinois Appellate and ultimately the Illinois Supreme Court determined that medical expenses were considered "compensation" under the Act and allowed penalties for the nonpayment of same, finding that the imposition of penalties under §19(k) and attorney fees under §16 was not precluded in cases where the delay in payment occurred prior to entry of the award by the arbitrator or issuance of a decision by the Commission on review. *McMahan*, 702 N.E.2d at 549. The supreme court noted that "[t]he claim that such fees and penalties must be based on an existing award of benefits, the payment of which is delayed, was rejected by our court as involving 'too narrow a reading of the statutory sections involved, and too broad a reading of *Brinkmann*.'" (Citing *Board of Education v. Industrial Commission*, 93 Ill. 2d 1, 12, 442 N.E.2d 861 (1982). Likewise, I believe the majority in this case has given §§19(k), 19(l) and 16 too narrow a reading.

Furthermore, §16 specifically contemplates an award of attorneys' fees when an insurer or its agent "...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..." Denying authorization for surgery that by all accounts is reasonable and necessary as well as causally related -- without any countervailing medical opinion or additional evidence other than a single, unsubstantiated reference in a VA record to a prior knee "surgery" that supposedly occurred a decade earlier and which in actuality never happened -- is the epitome of "frivolous defenses which do not present a real controversy."

And to those who argue that there already is a mechanism to obtain authorization for medical treatment -- namely §19(b)/§19(b-1) -- I say where is the deterrence in that? If availing oneself of judicial proceedings is sufficient recourse when authorization for treatment is unfairly denied, what is the rationale for penalties for the failure to pay for that treatment?

18IWCC0295

I would submit that refusing to authorize essential and oftentimes critical treatment, without adequate justification, is just as harmful if not more so than the failure to pay a bill after the fact. More to the point, the human toll, and the deleterious effect on the health and well-being of injured workers in legitimate need of medical care, in my humble opinion, far outweighs the monetary need to pay for same, and should be protected just as vigilantly.

Therefore, I believe the Arbitrator got it right – imposing §19(l) penalties for each day the authorization has been unreasonably withheld, as well as §16 attorneys' fees for the vexatious conduct associated with that refusal. However, should the majority's opinion withstand judicial appeal in this case, or if no such appeal issues, I would ask our legislature to consider amending the Act to address the vast potential for abuse that exists in cases such as this, and provide the Commission with the necessary tools to penalize those who engage in such behavior and hopefully deter similar conduct in the future.

Thomas J. Tyrrell

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

O'NEIL, JUSTIN
Employee/Petitioner

Case# **16WC031519**

JGS MARINE LLC D/B/A MASTERCRAFT BOATS
Employer/Respondent

18IWCC0295

On 6/16/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

4835 MARKHAM M JEEP & ASSOC PC
JASON W HAUCK
200 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

5265 WOLF LAW LTD
STEVEN WOLF
25 E WASHINGTON ST SUITE 801
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

18IWCC0295

☐ 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)

Justin O'Neil
Employee/Petitioner
v.
JGS Marine, LLC d/b/a Mastercraft Boats
Employer/Respondent

Case # **16** WC **31519**

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 Greg Dollison, Arbitrator of the Commission, in the city of **Rockford, Illinois** on **May 15, 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 **02/11/2016**, 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 **$60,000.20**; the average weekly wage was **$1,153.85**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$0.00** 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 authorize the treatment as prescribed Dr. Roger Chams of Illinois Bone and Joint Institute, including but not limited to arthroscopic surgery of his right knee, open removal of patellar bursa, and further treatment related to post-surgical rehabilitation of his right knee pursuant to Section 8(a) of the Act.

Respondent shall pay penalties under section 19(l) of the Act of $6,900.00 which represents an amount of $30 per day from Petitioner's last date of medical treatment. Respondent shall pay attorneys' fees under section 16 of the Act of $1,380.00 representing 20% of the penalties 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.

Signature of Arbitrator

6/15/17
Date

ICArbDec p. 2

JUN 16 2017

Statement of Facts:

18IWCC0295

Petitioner, Justin O'Neil, testified that he had been employed by Respondent, Mastercraft of Chicago, since early 2015 as a boat technician. His duties included mechanical work, installation of boat accessories, trailer maintenance and repair, winterizing boats and other general boat maintenance. This was Petitioner's full-time job. He stated that he also worked part-time elsewhere on some weekends.

Petitioner testified that on February 11, 2016, he was working on a Mastercraft boat. At that time, he was installing a swim platform to the rear of the boat. The swim platform weighed between 50 and 75 pounds. He stated that while lowering the swim platform down to its supporting brackets, exercising caution to not damage the finish on the boat, he lowered himself to his right knee on the concrete floor. When his knee hit the floor, he felt a sharp pain or pop, and immediately twisted his knee in response. Petitioner stated that there were several witnesses to the accident, and his supervisor was informed immediately. Petitioner testified that he attempted to continue with work on that Thursday, but left early because he was unable to finish the day. He missed his shift on the following day, Friday, February 12, 2016 due to pain in his injured knee.

Petitioner visited the VA hospital on Saturday, February 13, 2016, two days after the work place accident. VA records show Petitioner presented with a history that he "…was kneeling on cement floor 2 days ago and felt a pain in right knee with swelling. Has used ice, elevation with sl resolution. [T]aking motrin with some relief also. Thought could get joint aspiration in ER." In the nurse's note portion of the visit, it is noted that "… pt was kneeling on concrete at work then noticed when he stood up pain in R knee/ pt. has been using RICE [sic] and IBUPROFEN 800mg as treatment for knee and it has been getting better/states he exercises daily on stairmaster/ r knee positive for swelling and minimal fluid movement/ pt able to extend and flex without assistance with minimal pain/ all pulses present/ pt able to dorsal and plantar flexion without any pain." Also noted is "…pt states this happened in 2001 when he was active duty – performed surgery on knee, which pt describes as a[n] incision and drainage." Petitioner was diagnosed with prepatellar bursitis. The treatment plan consisted of a pull on knee sleeve, ice, elevation, and Norco for pain. Also noted was limited flexion and take motrin until resolved. Lastly, Petitioner was advised to follow up in 7-10 days if not better. (PX 1, pp.49-56)

VA records indicate that Petitioner returned to the hospital on February 23, 2016. The records indicate Petitioner presented at that time for a routine annual "PC" examination. The records note that he had been recently diagnosed with prepatellar bursitis. It was noted that he had ongoing knee discomfort and an examination of the knee indicated that he had "mild infra-patellar swelling". Petitioner was referred to the "ortho clinic" and given kneepads. (PX1, pp. 43-44)

Petitioner returned to the VA Hospital on March 4, 2016 for an orthopedic surgery consult. The "History of Present Illness" recorded at that time was that "… the patient was at work while kneeling on concrete and felt pain and swelling in the right knee. He went to the emergency Room on 2/13/2016 because of painful swelling… Currently his swelling is less and his pain is better, but he still has some aching pain at the anterior aspect of the knee." The treating orthopedist noted Petitioner had prepatellar bursitis. He indicated that the treatment plan was "…to avoid kneeling, and if kneeling is necessary, to completely pad and protect the area while kneeling." The orthopedist added "Otherwise, the bursitis may return or persist." The orthopedist also opined that aspiration or surgery was not necessary at that time. Petitioner was to return on an as needed basis. (PX 1, p.41)

Petitioner testified that he continued working for Respondent beginning the following Monday and did not miss any time from work indicating he didn't want to lose his job and "I tried to toughen it out." Petitioner

testified that the amount of fluid in his knee would fluctuate, getting as large as a racket ball at times. Petitioner provided that although the amount of fluid in the knee waxed and waned, there was always an amount of fluid on his knee. Petitioner explained that the condition has been and is very painful. He is forced to kneel on his knees throughout much of the day at work and that kneeling aggravates his knee pain.

Petitioner testified that after four months of "toughing it out," he was sent by his employer to Dr. Culberson of Advocate Occupational Health in Lake Zurich. The records document an office visit on June 14, 2016. Under the section identified as "Patient Description of Accident" it's noted Petitioner "was installing a swim platform on a boat, and had a sharp pain at right knee (Concrete floor)." Also noted in the "History of Present Illness", it was recorded that Petitioner advised that he "... Was kneeling on right knee at work 4 months ago and began having pain in right knee later that night..." An examination of the right knee revealed swelling present over the patellar area. Dr. Culberson diagnosed prepatellar bursitis of the right knee and instructed Petitioner to use ice, elevate the leg and take over-the-counter Ibuprofen. The doctor also referred Petitioner to an Orthopedic surgeon at Illinois Bone and Joint Institute. The doctor noted that he contacted Respondent regarding the visit. Petitioner was returned to regular duty work. (RX 2)

Petitioner first saw Dr. Chams on June 21, 2016. Records submitted show Petitioner provided a history that he injured his right knee on February 11, 2016 when he was working on a boat. He told the doctor that he was holding a heavy swim platform that goes on the back of the boat and was trying to bring it down to his knees when he twisted his right knee and felt a pop. The doctor noted Petitioner continued to have swelling at the anterior aspect of the knee as well as pain deep to the patella. Dr. Chams diagnosed right knee prepatellar bursitis, rule out meniscus tear. The doctor aspirated 20 mL of fluid from the prepatellar bursa of the right knee. Additionally, one mL of Marcaine and one mL of Kenalog were injected into the knee. Petitioner was returned to full duty work with a caveat to allow for rest or excuse from work if complaining of knee pain. An MRI was also prescribed to rule out a meniscal injury. (PX 2)

Petitioner returned to Dr. Chams on July 5, 2016. Petitioner reported that the aspiration and injection did not help his symptoms. The swelling returned almost immediately. Petitioner had undergone the MRI and the results were reviewed. Dr. Chams noted that the MRI revealed evidence of prepatellar bursitis with mild chondromalacia of the patella and a small joint effusion with no meniscal tear. The doctor recommended avoiding painful positions and activities. He provided a work status of light duty and light kneeling. The doctor also provided that Petitioner may use the elliptical for exercise. (PX 2)

Petitioner returned to Dr. Chams on July 19, 2016 with continuing complaints of pain in his right knee. His knee was aspirated once again. He received another injection of Marcaine and Kenalog. The knee was aspirated again on August 16, 2016 and Dr. Chams ordered a repeat MRI. (PX 2)

On September 27, 2016, Dr. Chams noted the MRI demonstrated a significant prepatellar bursal inflammation as well as some mild chondromalacia and a lateral tilt of the kneecap. Dr. Chams diagnosed chondrolmalacia pain and prepatellar bursitis to the right knee. At that time, Dr. Chams recommended surgery consisting of right knee arthroscopy, open removal of prepatellar bursa. His light duty restrictions were continued. (PX 2)

Records submitted show that on October 10, 2016, Respondent approved the proposed surgery. (PX 2) Petitioner testified that he delayed going forth with the surgery because Respondent was "really busy" and he was the "only tech." Petitioner provided that he thought he would "tough it out" and proceed with the surgery in the winter when Respondent was not as busy.

On December 2, 2016, Dr. Chams recorded that the proposed surgery was scheduled for December 17, 2016. On December 8, 2016, Dr. Chams received notification that Respondent was "revoking the surgery authorization for Justin O'Neil. Additional investigation needs to be completed." (PX 2)

Petitioner testified that he had a procedure on his right leg while deployed on an aircraft carrier while enlisted in the US Navy. Petitioner demonstrated and this Arbitrator observed a visible scar located 2 to 3 inches below his right knee joint line. Petitioner testified that prior to February 11, 2016, he never had any injuries or treatment associated with his right knee. The procedure to Petitioner's lower right leg that result in the above reference scar is referenced in his VA records. According to the submitted records, on July 8, 2005, Petitioner presented for a post-discharge examination of a veteran. The examination included a comprehensive baseline examination for all body systems. Noted in the records was Petitioner's assertion that in January 2002 he had two lipomas (benign tumor composed of adipose tissue (body fat). It is the most common benign form of soft tissue tumor. Lipomas are soft to the touch, usually movable, and are generally painless. Many lipomas are small (under one centimeter diameter) but can enlarge to sizes greater than six centimeters) removed from his right leg. According to the historian there was a visible scar about 1 inch by 1/3 inch wide below his right kneecap. The scar had a lighter complexion and was nontender and nonadherent to the underlying tissue. Amongst the relevant diagnosis is an indication for "scar on the right leg. He has a residual scar for the removal of a lipoma on his right leg." (PX 1, pp.107-108) Petitioner testified that he has never received treatment to his right knee.

Petitioner testified that he resigned his employment with Respondent in August 2016. He indicated that his injury and knee condition had nothing to do with his decision to terminate his employment. He then began working full-time at Fox Lake Harbor. Petitioner also testified that his knee has not improved. He indicated that none of his treating physicians have placed him at maximum medical improvement for his knee condition, and he would like to undergo the prescribed surgical intervention.

In support of the Arbitrator's decision with respect to (F), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner sustained an undisputed accident on February 11, 2016. On said date, Petitioner was lowering a swim platform down to its supporting brackets, exercising caution to not damage the finish on the boat, he lowered himself to his right knee on the concrete floor. When his knee hit the floor, he felt a sharp pain or pop, and immediately twisted his knee in response.

Petitioner initially sought treatment at the VA Hospital's ER on February 13, 2016, two days after the work place accident. VA records show Petitioner provided a history that he "…was kneeling on cement floor 2 days ago and felt a pain in right knee with swelling. Has used ice, elevation with sl resolution. [T]aking motrin with some relief also. Thought could get joint aspiration in ER." The nurse's note portion of the visit, show "… pt was kneeling on concrete at work then noticed when he stood up pain in R knee/…[right] knee positive for swelling and minimal fluid movement…" Petitioner was diagnosed with prepatellar bursitis. The treatment plan consisted of a pull on knee sleeve, ice, elevation, and Norco for pain.

Petitioner returned to the VA Hospital on February 23, 2016. Petitioner presented at that time for a routine annual "PC" examination. Although the purpose of the visit was unrelated to this claim, Petitioner reported ongoing knee discomfort. The records note that he had been recently diagnosed with prepatellar bursitis. An examination of the knee demonstrated mild infra-patellar swelling. Petitioner was referred to the "ortho clinic" and given kneepads.

Petitioner returned to the VA Hospital on March 4, 2016 for an orthopedic consult. The history recorded was "... the patient was at work while kneeling on concrete and felt pain and swelling in the right knee. He went to the emergency Room on 2/13/2016 because of painful swelling... Currently his swelling is less and his pain is better, but he still has some aching pain at the anterior aspect of the knee." The treating orthopedist noted Petitioner had prepatellar bursitis and recommended Petitioner "...avoid kneeling, and if kneeling is necessary, to completely pad and protect the area while kneeling." The orthopedist added "Otherwise, the bursitis may return or persist."

Petitioner did not miss any time from work. Petitioner explained that although the condition was painful, "I tried to toughen it out." He is forced to kneel on his knees throughout much of the day at work and that kneeling aggravates his knee pain. After four months of "toughing it out," he was sent by his employer to Dr. Culberson of Advocate Occupational Health in Lake Zurich. The records document an office visit on June 14, 2016. Under the section identified as "Patient Description of Accident" it's noted Petitioner "was installing a swim platform on a boat, and had a sharp pain at right knee (Concrete floor)." Also noted in the "History of Present Illness", it was recorded that Petitioner advised that he "... Was kneeling on right knee at work 4 months ago and began having pain in right knee later that night..." After performing an examination, Dr. Culberson diagnosed prepatellar bursitis of the right knee. He instructed Petitioner to use ice, elevate the leg and take over-the-counter Ibuprofen. The doctor noted that he contacted Respondent regarding the visit. The doctor also referred Petitioner to an Orthopedic surgeon at Illinois Bone and Joint Institute.

Petitioner first saw Dr. Chams on June 21, 2016. Records submitted show Petitioner provided a history that he injured his right knee on February 11, 2016 when he was working on a boat. He told the doctor that he was holding a heavy swim platform that goes on the back of the boat and was trying to bring it down to his knees when he twisted his right knee and felt a pop. The doctor noted Petitioner continued to have swelling at the anterior aspect of the knee as well as pain deep to the patella. Dr. Chams diagnosed right knee prepatellar bursitis, rule out meniscus tear.

During the course of treatment, Dr. Chams aspirated the right knee on three different occasions. He also received injections of Marcaine and Kenalog on two different occasions. By August 16, 2016, Dr. Chams ordered a repeat MRI and on September 27, 2016, Dr. Chams noted the MRI demonstrated a significant prepatellar bursal inflammation as well as some mild chondromalacia and a lateral tilt of the kneecap. Dr. Chams diagnosed chondrolmalacia pain and prepatellar bursitis to the right knee. At that time, Dr. Chams recommended surgery consisting of right knee arthroscopy, open removal of prepatellar bursa.

Petitioner admits to a prior procedure involving his right lower leg in 2001 or 2002. Petitioner testified that this prior procedure was 3 to 3.5 inches below the joint line of the knee. Petitioner demonstrated and this Arbitrator observed a visible scar located 2 to 3 inches below his right knee joint line. Petitioner testified that prior to February 11, 2016, he never had any injuries or treatment associated with his right knee. The procedure to Petitioner's lower right leg that result in the above reference scar is referenced in his VA records. According to the VA's records, on July 8, 2005, Petitioner presented for a post-discharge examination of a veteran. The examination included a comprehensive baseline examination for all body systems. Noted in the records was Petitioner's assertion that in January 2002 he had two lipomas removed from his right leg. According to the historian there was a visible scar about 1 inch by 1/3 inch wide below his right kneecap. Amongst the relevant diagnosis is an indication for "scar on the right leg. He has a residual scar for the removal of a lipoma on his right leg."

Petitioner's knee, at and above the joint line, was free from any visible scarring and his medical records indicate that no prior procedures were ever performed on his right knee. Respondent provided no evidence to contradict the fact that Petitioner's knee ever received any medical attention or treatment prior to February 11, 2016, or since his last visit with Dr. Chams.

Respondent's argument that the VA records contain proof that Petitioner did in fact receive treatment to his knee prior to his work place accident is without merit. A removal of benign tumor (lipoma) more than 14 years prior to this claim, that was located below the knee cap, is not evidence of Petitioner undergoing treatment to his right knee prior to his workplace accident. As noted above, Petitioner's knee exhibited no signs medical intervention.

All of the medical chart notes (VA Hospital, Dr. Culberson and Dr. Chams) in this case is consistent with and further bolster the testimony of Petitioner. The VA records from February 13, 2016, indicate that the injury sustained by Petitioner, prepatellar bursitis, occurred at work, which was memorialized two days after the accident. The same diagnosis was proffered by Dr. Culberson and Dr. Chams four months after the accident.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that a causal relationship exists between his present right knee condition of ill-being and the accident that took place on February 11, 2016, while working as an employee for Respondent.

In support of the Arbitrator's decision with respect to (K), Is Petitioner entitled to any prospective medical care, he Arbitrator finds as follows:

As noted above, all of the medical providers opined that Petitioner has prepatellar bursitis. Petitioner's treating physician, Dr. Chams, has aspirated the right knee on three occasions. He also injected the right knee twice with Marcaine and Kenalog, all to no avail. By September 27, 2016, Dr. Chams noted the repeat MRI demonstrated a significant prepatellar bursal inflammation as well as some mild chondromalacia and a lateral tilt of the kneecap. Dr. Chams diagnosed chondrolmalacia pain and prepatellar bursitis to the right knee. At that time, Dr. Chams recommended surgery consisting of right knee arthroscopy, open removal of prepatellar bursa.

Having reconciled in favor of Petitioner and finding the requisite causal relationship, the Arbitrator finds that Respondent shall authorize the surgery as prescribed by Dr. Chams on September 27, 2016.

In support of the Arbitrator's decision with respect to (M), Should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

Respondent offered no good-faith arguments at trial indicating there was a genuine controversy pertaining to the payment of benefits under the Act, i.e. authorizing the surgery. The Arbitrator further finds that all the medical records indicate that Petitioner's injuries are compensable under the Act.

On September 27, 2016, Dr. Chams recommended surgery consisting of right knee arthroscopy, open removal of prepatellar bursa. On October 10, 2016, Respondent approved the proposed surgery. Petitioner delayed going forth with the surgery because Respondent was "really busy" and he was the "only tech." Petitioner wanted to proceed with the surgery in the winter when Respondent was not as busy. Consistent with his wishes, on December 2, 2016, Dr. Chams scheduled the proposed surgery for December 17, 2016. Six days after scheduling the surgery, or December 8, 2016, Dr. Chams received notification that Respondent was "revoking the surgery authorization for Justin O'Neil. Additional investigation needs to be completed."

It appears that based on the "...additional investigation..." Respondent relied upon the February 13, 2016 VA chart note to dispute that Petitioner's need for surgery was causally related to the work accident. The chart notes in part states: "...pt states this happened in 2001 when he was active duty – performed surgery on knee, which pt describes as a[n] incision and drainage." Respondent reliance upon this single statement, a poor translation, is at best ambiguous. Petitioner admits to a prior procedure involving his right lower leg in 2001 or 2002. VA records from July 8, 2005 show Petitioner presented for a post-discharge examination of a veteran.

The examination included a comprehensive baseline examination for all body systems. Noted in the records was Petitioner's assertion that in January 2002 he had two lipomas (benign tumor composed of adipose tissue (body fat).) removed from his right leg. According to the historian there was a visible scar about 1 inch by 1/3 inch wide below his right kneecap. Amongst the relevant diagnosis is an indication for "scar on the right leg. He has a residual scar for the removal of a lipoma on his right leg."

Petitioner's knee, at and above the joint line, was free from any visible scarring and his medical records indicate that no prior procedures were ever performed on his right knee. Records submitted from the VA Hospital chart numerous visits dating back to 2005. "[A]dditional investigation" would have shown that other than the July 8, 2005 reference, there are no records showing Petitioner had any treatments to his right knee. Respondent provided no evidence to contradict the fact that Petitioner's knee ever received any medical attention or treatment prior to February 11, 2016, or since his last visit with Dr. Chams.

Respondent's argument that the VA records contain proof that Petitioner did in fact receive treatment to his knee prior to his work place accident is unreasonable and without merit. As stated earlier, a removal of benign tumor (lipoma) more than 14 years prior to this claim, that was located below the knee cap, is not evidence of Petitioner undergoing treatment to his right knee prior to his workplace accident.

Respondent offered no evidence that Petitioner's current state of ill being is related to anything other than his work place accident on February 11, 2016. Respondent had access to a complete set of Petitioner's VA records. Those records contain no mention of any treatment to Petitioner's right knee prior to February 13, 2016. Practicality would dictate that Respondent should have known that the 2001 treatment referenced in the February 13, 2016 VA chart note on page 55 of the records, was a clear reference to the procedure completed in 2002 to Petitioner's lower leg. In short, there is no evidence that Petitioner's right knee has ever received medical treatment before February 11, 2016. Respondent relied on speculation and ambiguity and did so in an unreasonable and vexatious manner.

Respondent relied on no medical opinion by a medical professional in asserting that Petitioner's right knee condition of ill-being was not causally related to his work place accident. Respondent did not exercise its rights under Section 12 of the Act. Respondent did not exercise its rights under section 8.7 of the Act. Instead, Respondent relied upon a single and poor translated statement. Respondent offered no evidence that Petitioner's current state of ill being is related to anything other than his work place accident on February 11, 2016.

The Arbitrator finds that in failing to complete its due diligence through remedies provided to it in the Act, Respondent has created an unreasonable and vexatious delay in paying benefits to Petitioner, medical and otherwise, for treatment plainly and obviously related to Petitioner's work place accident on February 11, 2016.

"The standards under section 16 and section 19(k) are similar. Both require an unreasonable or vexatious delay in payment." Vulcan Materials Co. v. Industrial Comm'n, 842 N.E.2d 204 (2005). The Arbitrator finds that the delay in medical treatment incurred by Petitioner has been vexatious and unreasonable, for the above-mentioned reasons. There is no clear controversy that would support Respondent's delay in benefits.

"Typically, an employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act." Matlock v. Industrial Comm'n, 746 N.E.2d 751 (2001). The Arbitrator finds that Respondent has not used good-faith in determining liability in the instant case. Respondent presented no reasonable challenge to the medical records, witness testimony, or underlying facts of this case at trial. Respondent failed to use the tools at its disposal provided by the Act. Respondent failed to seek a Section 12 exam or a Utilization Review.

"Good faith must be assessed objectively, thus the question is whether an employer's denial of benefits was reasonable." Electro–Motive Division, 621 N.E.2d 145. The record is devoid of any reasonable grounds for the denial of benefits. Respondent's reliance upon the VA record of February 13, 2016 as evidence of prior medical issues with Petitioner's right knee is not reasonable. The credibility of the argument gets strained even further when the VA record indicating a lower leg procedure in 2002 is considered. The reasonable inference is that the only procedure ever performed on Petitioner's leg is the one referenced in the medical records. A "lack of record" is never reasonable evidence to show the likelihood of a prior injury. Simply put, if there was a procedure performed on Petitioner's right knee it would be in his medical records. The fact that there is no such record indicates there was never any procedure to that knee.

"The employer bears the burden of demonstrating that its denial of benefits was reasonable." Electro–Motive Division, 621 N.E.2d 145. At trial, Respondent offered no evidence or testimony that would lead a reasonable person to conclude that denial of benefits was appropriate or justifiable. Respondent failed to rebut any of the medical records or witness testimony offered by Petitioner.

There is no contrary opinion for the need of medical intervention. There is no Utilization Review report indicating that the procedure is inappropriate under nationally recognized medical standards. There is no evidence that Petitioner suffers from a pre-existing condition. Respondent did not uncover any new information in regard to Petitioner's previous healthcare that could lead a reasonable person to believe that his condition of ill-being was not related to his well-documented work place accident. Having said that, case law is clear that Section 19(k) penalties for future medical are not appropriate.

However, the Arbitrator finds that Respondent is liable for penalties under Section 19(l) of the Act for without good and just cause failing, neglecting, refusing, and unreasonably delaying payments under Section 8(a) of the Act, i.e. authorizing the surgery. These penalties will amount to $30 per day beginning on the date of Petitioner's last medical treatment on September 27, 2016, and total in the amount of 230 days or $6,900.

The Arbitrator further finds that Respondent is liable for attorneys' fees under section 16 of the Act for engaging in frivolous claims that do not present a real controversy, and creating an unreasonable and vexatious delay by continuing proceedings in that vein. Attorneys' fees will amount to 20% of the penalties awarded, or $1,380.00

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

JIMMIE GARDNER,

Petitioner,

vs.

NO: 17 WC 266

CITY OF CHICAGO,
DEPT. OF TRANSPORTATION,

Respondent.

18IWCC0296

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 and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the "Order" section on page 2 and the "Medical Bills" section on page 4 to strike the references regarding the deadline by which proof of payments were required for Respondent to receive credit for medical bills paid. Consistent with the standard language used in Decisions on Review, Respondent is entitled to credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

We also modify the medical award. Petitioner's Exhibit 1 claims there is a balance due of $2,470.00 for Orthopaedics and Rheumatology of the North Shore. However, a review of the actual bill shows that the total charges were only $1,235.00. It appears the amounts in the "Fee" column were double counted because both the individual charges and the sub-total for each visit date were added together. Therefore, we modify the decision to reflect a total medical award of $93,016.86 ($66,186.31 + $25,595.55 + $1,235.00), subject to the fee schedule in §8.2 of the Act.

18IWCC0296

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 48.375 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the 22½ % loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $93,016.86 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

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: MAY 9 – 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 4/11/18
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARDNER, JIMMIE
Employee/Petitioner

Case# **17WC000266**

CITY OF CHICAGO-DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0296

On 8/22/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

1067 ANKIN LAW OFFICE LLC
HOWARD ANKIN
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

0010 CITY OF CHICAGO
NICHOLAS J PERRONE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60603

J. Gardner v City of CHGO, 17 WC 0266

18IWCC0296

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

JIMMIE GARDNER
Employee/Petitioner

Case # 17 WC 0266

v.

CITY OF CHICAGO - DEPARTMENT OF TRANSPORTATION
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 Jeffrey Huebsch, Arbitrator of the Commission, in the city of Chicago, on July 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

18IWCC0296

FINDINGS

On June 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 $72,818.07; the average weekly wage was $ $1,400.35.

On the date of accident, Petitioner was 61 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.

The Parties agreed that all TTD benefits had been paid and there is neither an over-payment or an underpayment of benefits.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $94,251.86, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be provided credit for any payment made through date of hearing. Respondent shall provide Petitioner with proof of payments made.

Respondent shall pay Petitioner permanent partial disability benefits of $755.22/week for 48.375 weeks, because the injuries sustained caused the 22-1/2 % loss of use of the right leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner all compensation that has accrued from 6/17/2016 through 7/14/2017 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

August 21, 2017

Date

ICArbDec p. 2

AUG 22 2017

FINDINGS OF FACT

Petitioner has worked for Respondent for the past 25 years in the Department of Transportation. His job title is Motor Truck Driver. Respondent has a fleet of double bucket work trucks for use in maintaining City property, such as replacing or repairing street lights or traffic control devices. The truck that Petitioner drives has a double bucket boom on the back and legs for securing the truck when the booms are deployed. A typical work day requires Petitioner to drive a foreman, two linemen, and a laborer from jobsite to jobsite and then assist on site. A typical day involves the Petitioner's crew traveling to 5 or 6 details or jobsite.

The cab of the boom truck is several feet off the ground. The truck has a two-step ladder which enables the boom truck's driver to ascend and descend from the cab.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on June 17, 2016. Petitioner fell getting out of his work truck. Petitioner fell hard on his right leg, landing on an uneven dirt ground surface. Petitioner felt his right knee twisting on impact. Petitioner fell back landing on his rear. The foreman, Art Martinez and the laborer, Felix Arzario, were direct eye-witnesses to the accident. They filed written accident reports with Respondent.

Petitioner attempted to walk off the injury upon getting up and it was determined to call Petitioner's foreman, Tony Lugwich, immediately. Foreman Lugwich came to the accident scene and drove Petitioner to Mercy Works for immediate medical attention. Mercy Works is Respondent's occupational clinic.

Petitioner has never had any prior problems with his right leg or knee. He testified that he had four prior work injuries with Respondent. About 23 years ago, Petitioner sustained an injury to his right Achilles tendon requiring surgery. About 11 years ago, Petitioner required a hernia operation. 10 years ago, Dr. Heller of Mercy Works performed a left shoulder rotator cuff repair. 4 years ago, Dr. Heller performed a left rotator cuff repair.

Petitioner testified that Mercy Works released him to light duty work on the day of accident and instructed Petitioner to return about 3 weeks later. Mercy Works would obtain authority for an MRI to be performed to Petitioners right knee. Petitioner's leg continued to hurt and he contacted his employer to assist in the approval process. Petitioner returned to Mercy Works about 3 weeks later and was given a script to obtain an MRI. The MRI was performed about 2 weeks later on a Saturday. Petitioner returned to Mercy Works two days later, on Monday. The MRI was reviewed to and Petitioner was instructed to see an Orthopedic knee physician. The MRI showed a tear of the medial meniscus.

On 7/21/16, Petitioner saw Dr. Steven Sclamberg at Lakeshore Occupational Medicine in initial consultation. The history contained in Dr. Sclamberg's notes was consistent with Petitioner's testimony that the patient twisted his right knee exiting his electrical work truck. Dr. Sclamberg noted the pain complaints consistent with the MRI diagnostic test and prescribed arthroscopic surgery with partial meniscectomy and for Petitioner to remain off work. (PX 2)

On 8/22/16 surgery was performed at Lakeshore Surgery Center. The arthroscopic surgery performed was a partial medial meniscectomy and partial lateral meniscectomy, with synovectomy. (PX 3) Petitioner remained off work. Petitioner returned post operatively for check-up on 9/6/16 and was prescribed physical therapy at ATI Physical Therapy. Petitioner returned on 10/18/16 where work conditioning was discussed to begin following physical therapy. Petitioner remained off work. (PX 2)

On 11/7/16, Petitioner started physical therapy at ATI. Petitioner saw Dr. Sclamberg on 11/29/16. Petitioner reported pain and throbbing complaints to his knee but was starting working conditioning and remained off work. On 1/13/17, Petitioner saw Dr. Sclamberg work conditioning was helping the throbbing and the knee was feeling better. Fluid was noted on the knee. Petitioner remained off work. On 2/10/17, Petitioner saw Dr. Sclamberg. Work conditioning was continued and Petitioner remained off work. On 3/9/17, Petitioner had completed 71 visits with ATI and was released from further work conditioning care. (PX 2 & 4)

On 3/10/17, Petitioner was seen for the last time by Dr. Sclamberg. Petitioner reported that he had minimal pain in his knee. The physical exam was largely benign, but there was concern for fluid in the knee. Dr. Sclamberg aspirated the knee. Petitioner was returned full duty unrestricted work, effective March 16, 2017.

Petitioner testified that his knee is not the same as prior to the accident. It is not 100% of what it used to be. His knee and leg do not feel as strong as they used to. The knee feels like is tight. Petitioner drives with a high brake. When Petitioner climbs down to a surface he cannot see, he is hesitant. His knee tightens and stiffens with the work day. The knee does not feel flexible. Petitioner is over 60 years old and his body does not recover like it used to and he does not have the same physical fitness he used to have to overcome this injury.

Petitioner testified that outstanding medical bills remained in the amount of $94, 251.86 as documented in Petitioner's Exhibit #1.

The Parties stipulated that Petitioner's current condition of ill-being is causally related to the injury.

CONCLUSIONS OF LAW

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

Petitioner's testimony is found to be credible.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

MEDICAL BILLS

The Arbitrator finds the treatment rendered to Petitioner to have been reasonable and necessary. The Arbitrator awards direct payment to Petitioner in the amount of $94,251.96, less proof of payment prior to the entry of this award, subject to the fee schedule, and in accordance with §§8(a) and 8.2 of the Act.

NATURE AND EXTENT

The Arbitrator finds that the injuries sustained caused Petitioner to suffer the 22-1/2% loss of use of the right leg, in accordance with §8(e)12 of the Act.

The Arbitrator's §8.1(b) analysis of the PPD calculation follows.

Neither Petitioner nor Respondent submitted a report documenting AMA impairment. Accordingly this factor is given no weight in determining PPD.

Petitioner is employed as a Motor Truck Driver, who operates sophisticated boom trucks. This machinery requires Petitioner to operate a braking system using his injured right leg. Petitioner testified after a work day driving his knee tightens and does not feel the same and has general discomfort. Petitioner further testified to discomfort in alighting and descending from his work truck. Petitioner is required to step down onto surfaces he is unable to see and in all weather conditions where the landing requires stability of Petitioner's knee. Petitioner also stands and is required to move and coordinate assistance with co-employees. Accordingly, Petitioners occupation is significant for requiring consistent use of the right knee and is susceptible at all times to further exacerbation, which would include the tightness feeling described by Petitioner. Evaluation of the occupation of Petitioner weighs heavily in the Arbitrator's evaluation of PPD, yielding a higher loss of use of a right leg in this case. This factor is given much weight in determining PPD.

Petitioner is one month short of age 62 at the time of hearing. Petitioner's advanced age would render the injury to his right knee more disabling. Petitioner testified his body does not recover like it did in his younger age. Further, Petitioner testified his age makes his personal fitness workouts less than when he was younger and makes it harder for him to compensate on his own. Petitioner is more prone to arthritic problems or the tightening the Petitioner testified. Accordingly, the Arbitrator ascribes a higher loss of use of the right leg based on Petitioner's advanced industrial work age. This factor is also given much weight in determining PPD.

Petitioner has worked for the Respondent for the past 25 years. He is paid a union scale and has returned to work full unrestricted duty. Petitioner has not lost any work hours since returning to work and was paid while off work. Petitioner works in a position highly not susceptible to any loss of future earnings capacity based on his injury. Accordingly, the Arbitrator's evaluation of future work capacity is that the industrial injury will have no impact on this factor. Accordingly, no weight is accorded this factor in determining PPD.

Petitioner underwent a surgery on 8/22/16 where both the lateral and medial meniscus were shaved down. The surgeon noted the mild disability at the final examination, consistent with Petitioner's subjective complaints. This factor is accorded much weight in determining PPD.

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 Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSA MARIA SANCHEZ,

Petitioner,

vs. NO: 11 WC 25277

FEDERAL ENVELOPE COMPANY,

Respondent.

18IWCC0297

DECISION AND OPINION ON REVIEW

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

On page 25 of the Decision of the Arbitrator, the Arbitrator wrote, "Based on the exhibits, it appears that all the medical bills through May 3, 2012 have been paid pursuant to the fee schedule and Sections 8(a) and 8.2 of the Act." Petitioner, through its Petition for Review and subsequent pleadings, claims two medical bills for medical treatment received prior to May 3, 2012, remain unpaid. Respondent, in response to Petitioner's pleading, argues those medical bills are unrelated to her May 4, 2011, work accident. The Commission finds Respondent, in effect, acknowledges those medical bills remained unpaid. The lack of controversy on this issue frees the Commission to find that said medical bills remain unpaid.

The Commission, concluding that two medical bills remain outstanding, also concludes, contrary to Respondent's stance, that both medical bills are causally related to the that was deemed necessary to treat the injuries from Petitioner's May 4, 2011, work accident. The Commission finds both medical bills were incurred in the course of Petitioner's treating physician, Dr. James Hill, seeking to find the cause of Petitioner's bilateral wrist pain.

18IWCC0297

Dr. Hill, after examining Petitioner on August 1, 2011, was unable to deduce the etiology of Petitioner's symptoms. He believed Petitioner could have been experiencing an atypical cervical radiculopathy or possibly an inflammatory arthropathy. To confirm or to eliminate either as a possible cause of Petitioner's symptoms, Dr. Hill prescribed an MRI of her cervical spine as well as a serologic workup. The serologic workup was performed at Northwest Community Hospital on August 4, 2011, and at cost of $936.00. The MRI was performed at Western Open MRI and Imaging on August 17, 2011, and at a cost of $1,002.72. Both the MRI and the serologic workup were attempts by Dr. Hill to identify the cause of Petitioner's symptomology. The Commission finds both courses of treatment, in addition to being reasonable and necessary, to be causally related to Petitioner's May 4, 2011, work injury.

The Commission affirms and adopts all other findings of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the additional sum of $1,938.72 for the medical treatment ordered by Dr. Hill and undertaken by Petitioner that was mistakenly omitted from the May 11, 2016, Decision of the Arbitrator.

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 $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.

MAY 9 - 2018

DATED:
KWL/mav
O: 03/20/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

SANCHEZ, ROSA MARIA
Employee/Petitioner

Case# **11WC025277**
13WC037473

FEDERAL ENVELOPE COMPANY
Employer/Respondent

18IWCC0297

On 5/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% 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:

1922 STEVEN B SALK & ASSOCIATES LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0210 GANAN & SHAPIRO PC
JOSEPH P BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 606054

18IWCC0297

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)

Rosa Maria Sanchez
Employee/Petitioner

v.

Federal Envelope Company
Employer/Respondent

Case # 11 WC 25277

Consolidated cases: 13 WC 37473

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 (for Elgin)** on **April 12, 2016**, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0297

FINDINGS

On the date of accident, **May 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 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 as explained *infra*.

In the year preceding the injury, Petitioner earned **$17,680.00**; the average weekly wage was **$340.00**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **no** dependent children.

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

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

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established a causal connection between her accident at work on May 4, 2011 and her bilateral wrist condition through May 3, 2012.

Medical Benefits

Petitioner's claim for payment of additional medical expenses beyond those paid by Respondent for treatment through May 3, 2012, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act is denied. Petitioner's claim for payment for any medical bills related to the motor vehicle accident on March 3, 2012 is specifically 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

May 11, 2016
Date

ICArbDec19(b) p. 2

MAY 11 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Rosa Maria Sanchez
Employee/Petitioner

v.

Federal Envelope Company
Employer/Respondent

Case # **11** WC **25277**

Consolidated cases: **13** WC **37473**

FINDINGS OF FACT

The parties appeared for a consolidated trial in the above captioned cases. The issues in dispute in this case include causal connection and Respondent's liability for payment of certain medical bills. Arbitrator's Exhibit[1] ("AX") 1. The issues in dispute in Case No. 13 WC 37473 include whether Petitioner sustained a compensable accident on October 3, 2013, causal connection, Respondent's liability for payment of certain medical bills, Petitioner's entitlement to temporary total disability benefits commencing October 4, 2013 through April 12, 2016 as well as Petitioner's entitlement to prospective medical care, which are addressed in a concurrent decision issued in that case. AX2. The parties have stipulated to all other issues. AX1 & AX2.

May 4, 2011

Rosa Maria Sanchez (Petitioner) testified that she was employed as a Machine Operator by Federal Envelope Company (Respondent) on May 4, 2011 and she had been so employed for six years. Petitioner explained that she packed envelopes that came out of a machine into boxes all day. Envelopes would come out of the machine in horizontal stacks of 2,400 envelopes. Petitioner explained that some of the envelopes would stick up and she would have to push them down to even out the stack. Petitioner testified that she would compress the stack of envelopes together and turn the stack of 2,400 envelopes over to place them in a box located to her left side. When the box was filled with envelopes, Petitioner would close the box and put it through a taping machine. After the box was closed, Petitioner would put the box down on a skid. She estimated that each box weighed about 60 pounds.

Petitioner testified that she compressed stacks of envelopes and turned them over many times throughout her eight hour shift per day. She explained that she did this for six years before May 4, 2011. Petitioner is right hand dominant.

On May 4, 2011, Petitioner testified that her hands started to hurt. She had experienced pain for a couple of months before this date. She felt a burning sensation in both wrists that went up to her elbows, but more on the right. Petitioner explained that the pain did not allow her to sleep.

On cross examination, Petitioner testified that she had bilateral wrist pain as well as numbness in her thumb, index finger, ring finger and pinky finger. Petitioner testified that she noticed pain when using her wrists to turn envelopes over and when lifting boxes to lift them up.

---

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)."

On May 4, 2011, Petitioner spoke with her supervisor, Dean, and reported that she could not work anymore because she had pain in her hands. She testified that her pain was very strong and explained that she could no longer work. Petitioner estimated her pain at a level of 6 or 7 out of 10 while she was packing envelopes. She testified that Dean sent her to Kelly in the Human Resources department and, thereafter, she was sent to Advanced Occupational Medicine and saw Dr. Sandra Bender (Dr. Bender).

Medical Treatment

On May 4, 2011, Petitioner testified that she saw Sandra Bender, M.D. (Dr. Bender) at Advanced Occupational Medicine. PX6 at 9-10. She was given a wrist splint for each hand and placed on light duty restrictions. *Id.* Petitioner testified that she then returned to work on May 5, 2011. On cross examination, Petitioner testified that she returned to light duty without repetitive work and no lifting over a certain amount of pounds. While she was no longer performing repetitive activities, Petitioner testified that the pain was less, but still at night she felt pain.

On May 27, 2011, Petitioner testified that she returned to Advanced Occupational Medicine. Bilateral wrist MRIs were ordered. PX6 at 10. On June 2, 2011, Petitioner underwent the recommended MRIs. PX2 at 21-24. The interpreting radiologist noted a scapholunate ligament sprain with focal signal abnormality by its scaphoid attachment suspicious for partial thickness tear on the left and a high grade partial tear of the scapholunate ligament on the right. *Id.*

Petitioner testified that she returned to Dr. Bender on June 9, 2011. The medical records reflect that Jacey Howard, PA-C, referred Petitioner to Srdjan (Andrei) Ostric, M.D. (Dr. Ostric). PX6 at 6. Ms. Howard noted "[bilateral] wrist pain presented [with] s/s DeQuervains, Tx [with] PT/splints [without] improvement. MRI on 6/2 revealed [left] partial tear/sprain of scapholunate & tear of [right] scapholunate. NSAIDs and phys therapy continued [without] improvement in pain (8/10) please eval & tx." PX6 at 6.

On June 16, 2011 Petitioner saw Dr. Ostric at Midwest Plastic & Reconstructive Surgery. PX1. Dr. Ostric noted the following history:

> Ms. Sanchez is a 43-year old right-hand dominant female who complained of pain early January 2011 and it has progressed over the past several months to the point where she is having difficulty at work. She works as a machine operator packaging envelop[e]s into boxes and it requires overhead lifting and significant use of her hands. She has been doing this for approximately six years. She is otherwise, healthy and I know she is taking anti-inflammatory medications, which you prescribed to her. I did review the MRIs. I am not concerned that she has a pathology in her wrist. These are all normal changes with aging such as the partial tear of the scapholunate, ligament and the lunate cyst.

Id. He noted that Petitioner's physical examination was more consistent with carpal tunnel syndrome and he ordered bilateral EMG/NCVs and prescribed physical therapy. *Id.* Petitioner remained on light duty work restrictions. *Id.*

On July 8, 2011, Petitioner underwent the recommended EMG/NCVs. PX4 at 41-43; PX6 at 2-5. The results included no evidence of bilateral median neuropathy, ulnar neuropathy or cervical radiculopathy. *Id.*

On July 8, 2011, Petitioner saw Priti Khanna, M.D. (Dr. Khanna) at Advanced Occupational Medicine Specialists. PX6 at 5. Dr. Khanna noted "repetitive work – started having pain in both hands [left] [illegible]

greater than the right now R>L. Numbness [bilateral] hand [bilateral] thumb, index & [right] ring at times. Numbness intermittent [without] nocturnal paresthesias [positive] weakness [R>L] [positive] neck pain [into] right shoulder & [without left] radicular pain in [positive left] elbow + forearm[.]" *Id.* Dr. Khanna reviewed Petitioner's EMG/NCV which showed no evidence of bilateral median neuropathy, ulnar neuropathy or cervical radiculopathy. *Id.* On July 12, 2011, Petitioner was released from care. PX6 at 10.

On July 29, 2011, Petitioner testified that she returned to Dr. Bender after an incident at work lifting garbage. See also PX6 at 10. Petitioner testified that Dr. Bender provided some conservative treatment then released her from her care and then referred her to Dr. Hill at Illinois Bone and Joint.

On August 1, 2011, Petitioner saw James Hill, M.D. (Dr. Hill) at Illinois Bone and Joint. PX2 at 2-3. He noted Petitioner's reported "longstanding history of bilateral upper extremity pain and paresthesias." *Id.* Petitioner reported "that she began to notice discomforts in her upper extremities bilaterally beginning May 2011. She feels that her right upper extremity is slightly more affected than the left. She attributes the onset of her symptoms to the repetitive requirements of work-related activities as a machine operator." *Id.*

Dr. Hill noted his review of Petitioner's bilateral EMG/NCV test results which showed partial, bilateral scapholunate tearing. PX2 at 2-3. He diagnosed Petitioner with chronic bilateral upper extremity pain and paresthesias of uncertain etiology. *Id.* Dr. Hill also indicated that Petitioner's clinical presentation did not suggest carpal tunnel syndrome or ulnar neuritis. *Id.* He believed that Petitioner could be experiencing some form of atypical cervical radiculopathy or even inflammatory arthropathy. *Id.* Dr. Hill ordered a cervical MRI and seriologic work-up. *Id.* On August 17, 2011, Petitioner underwent the recommended cervical MRI, which was normal. PX2 at 20.

Petitioner testified that she then saw Michael Vender, M.D. (Dr. Vender) on September 12, 2011 as referred by her prior attorney. The medical records reflect Petitioner's report of bilateral hand symptoms since May of 2011 including intermittent numbness in the thumbs and index fingers, a feeling of weakness and wrist pain into the palm. PX2 at 29-31; PX4 at 14-17, 35-36. Dr. Vender diagnosed Petitioner with bilateral tenosynovitis and administered a steroid injection into the right wrist. *Id.* He also ordered a second set of EMG/NCV tests, which were performed on the same day by Scott Heller, M.D. (Dr. Heller). PX4 at 37-38. Dr. Vender noted that the results were normal. *Id.*

Petitioner returned to see Dr. Vender on September 26, 2011 and he administered an injection into the left wrist. PX4 at 12-13, 33-34. On October 20, 2011, Dr. Vender noted that Petitioner did not respond to the injection and she was experiencing more pain and numbness, more prominently on the right. PX4 at 11, 32. She testified that she had bilateral wrist pain at this time while she was working and turning envelopes over and that she continued to work every day. Petitioner returned to Dr. Vender on November 17, 2011. PX4 at 10, 30-31. He noted that she was being followed for possible abnormal flexor tendon interconnections with continued radial symptoms bilaterally. *Id.* Dr. Vender diagnosed Petitioner with tenosynovitis and he administered a steroid injection into the left wrist. *Id.*

Petitioner testified that she then began to make complaints about pain in her bilateral elbows. She explained that the pain would begin in her right wrist and go up to her elbow. Dr. Vender's medical records reflect that Petitioner returned on December 1, 2011 reporting no response to the left wrist steroid injection and continued complaints with left-sided radial pain and right-sided radial and ulnar pain. PX4 at 9, 29. Her most significant complaint was also medial elbow pain on the left. *Id.* Dr. Vender diagnosed bilateral tenosynovitis and medial epicondylitis. *Id.* He administered an injection into the left elbow. *Id.*

On January 12, 2012, Petitioner reported that her left elbow injection did help, but she still had pain with twisting motions as well as medial elbow pain. PX4 at 7-8, 18, 28. Secondarily, Petitioner also reported ulnar right wrist pain and various other complaints in both upper extremities. *Id.* Dr. Vender referred Petitioner to occupational therapy, gave her an elbow sleeve and kept her released to full duty work. *Id.*

On February 20, 2012, Dr. Vender noted Petitioner's most prominent complaint to be left arm pain. PX4 at 5-6, 26. He maintained Petitioner's diagnoses of bilateral tenosynovitis and left medial epicondylitis. *Id.* Dr. Vender indicated that no aggressive treatment was recommended for the multiple upper extremities complaints and he ordered a home exercise program. *Id.* Petitioner saw the occupational therapist on the same date and was instructed in home exercises for the bilateral wrists and left elbow. PX4 at 25.

Motor Vehicle Accident

On March 13, 2012 Petitioner arrived at the emergency room at Northwest Community Hospital. PX3. She reported that she was in a motor vehicle accident with no airbag deployment hit on the driver side coming out of the parking lot by another oncoming vehicle. *Id.* She complained of mild headache, neck pain, and bilateral lower rib cage pain. *Id.* She was diagnosed with a head contusion and neck sprain. *Id.* Petitioner was discharged home the same day with instructions to follow up with her primary care physician. *Id.*

Continued Medical Treatment

Then, on May 3, 2012, Petitioner returned to Dr. Vender once more. PX4 at 4, 24. Petitioner reported that she was feeling the same as at her last visit with worsening pain located in the left elbow that had been occurring for five months and bilateral wrist pain that had been occurring one year ago. *Id.* Dr. Vender noted that Petitioner's complaints were mostly related to the right upper extremity, which were diffuse in nature, and that her pain radiated toward her shoulder and neck. *Id.* She also reported diffuse pain on the left stopping at the elbow. *Id.* Dr. Vender noted that Petitioner's daughter was present and translated for her. *Id.* He also noted that "[he] discussed the complaints today with the patient and her daughter. There has been difficulty with the location and consistency of complaints and findings. Would recommend followup. With her primary physician or possibly a rheumatologist." *Id.* Petitioner testified that this was her last visit with Dr. Vender. For approximately one year, Petitioner did not see any physician for treatment of her elbows or wrists.

On April 9, 2013, Petitioner testified that she went to see John O'Keefe, M.D. (Dr. O'Keefe) at Central Medical Specialists who she found in a newspaper. Dr. O'Keefe's records reflect Petitioner's report on that date of bilateral wrist and hand pain as well as handwritten notes with the following history:

> Patient here seeking 2nd opinion for bil hand & wrist pain from overuse injury at work. Pt packs envelopes & constantly rolling envelopes. Saw several doctors & was diagnosed with tendonitis. Was given cortisone injections on both hands by Dr Vender.

PX5 at 3. Petitioner testified that she then spent several months without any medical treatment for her hands, wrists or elbows, but she continued to work for Respondent.

October 3, 2013

Petitioner testified that on October 3, 2013 she was working for Respondent when she sustained an injury. She explained that she was working on machine "RA5," which is an envelope machine that packs envelopes. A conveyor belt is located at approximately knee level. Petitioner explained that her arm was hurting her a little bit at the time. She explained that she filled up a box that weighed 65-70 pounds and was placing it onto a skid stacked seven boxes high. Petitioner testified that she lifted up the box, but she felt pain in her hand and her hand was not stable after which the box came toward her and made her fall down.

Petitioner testified that her right hand started to hurt although she grabbed the box as it was coming down with both hands, but let the box go because her right hand did not "respond." Petitioner testified that the box fell and she fell onto her buttocks such that her hands and buttocks hit the floor. She explained that she felt a strong pain in her right hand, a lot of heat in her whole body, and dizzy for a few seconds.

Petitioner testified that her boss, Mitch, came to pick her up, but she did not let him because she was very dizzy and in a lot of pain. She described that the pain in her right hand was different than her pain before in that it was much stronger.

On cross examination, Petitioner testified that she had both hands on the outside corners of the box and she was using her right hand to propel the box upward onto the skid overhead. Petitioner testified that when she lifted the box overhead it was heavy and she felt pain in her right hand and she let the box go, which is when it fell. Petitioner also testified that she felt pain all the way from her right hand into her neck. The box did not stay where it was supposed to and she felt pain in her right hand. Petitioner stated that she had pain in both wrists, but it was stronger on the right side. She also had a little pain in her elbows and fingers, but no pain in her shoulders. She explained that she could not remember if the pain was different than the pain that she felt in 2011.

Medical Treatment

Petitioner testified that she was sent to U.S. Health Works, which is the same clinic as Advanced Occupational Medicine, but with a new name. The medical records reflect that Petitioner saw Alan Sisson, M.D. (Dr. Sisson), who recommended ice and heat and prescribed wrist splints while working. PX5 at 15; PX6 at 9-16. Petitioner was also instructed on home exercises, given Ibuprofen and released back to full duty work. *Id.*

Dr. Sisson also provided a letter dated October 3, 2013 addressed to Ms. Mueller summarizing Petitioner's care at his clinic in 2011. PX6 at 9-11. Dr. Sisson noted the following reported history in pertinent part:

> I had the opportunity to see Ms. Sanchez in our offices on the evening of October 3, 2013. She states that at approximately 5:25 PM, on October 3, 2013, she was lifting a box up onto an overhead area when she experienced pain in her right wrist that resulted in her losing control of the box, which then began to fall and she attempted to arrest that fall using her hands. She now complains of pain in both wrists that radiates up her arms toward her shoulders. She had a previous history of bilateral wrist injuries in 2011, that I was detail momentarily. Her statement at the time of this visit was that her previous wrist pain "never got better" since the time of the initial injury in approximately January of 2011. At this time, she is experiencing both pain and numbness in her hands bilaterally. She states that this discomfort in her wrists and numbness in her hands occurs frequently.

Id. Dr. Sisson noted that Petitioner previously presented on May 5, 2011 reporting bilateral wrist pain since January of 2011, which was diagnosed as a bilateral wrist sprain. *Id.* Petitioner underwent conservative treatment and diagnostic testing. *Id.* Her June 2, 2011 bilateral wrist MRIs showed a "high-grade partial tear of the scapholunate ligament[, and the] results for the left wrist showed a scapholunate ligament sprain that was suspicious for a partial-thickness tear." *Id.* Petitioner was referred to Dr. Ostric, who noted that Petitioner might be suffering from carpal tunnel syndrome, but her EMG showed no evidence of radiculopathy or neuropathy. *Id.* Dr. Ostric administered a steroid injection into the right wrist and Petitioner was released from care on July 12, 2011. *Id.*

Dr. Sisson also noted that "[o]n July 29, 2011, [Petitioner] returned with complaints of having injured her wrist and neck while lifting a sack of garbage. At that time, conservative treatment was instituted and she was again discharged from our care." *Id.* After an examination on October 3, 2013, Dr. Sisson diagnosed Petitioner with a bilateral wrist strain and released her back to work full duty. *Id.* Dr. Sisson also indicated in pertinent part:

> This particular complaint of injury aside, it appears that she continues to complain of chronic bilateral wrist pain which has been exhaustively investigated without a treatable underlying etiology discerned. I will evaluate her one additional time for this particular injury; however, I do not believe that, ongoing beyond that visit, we will have anything of substance to offer her in terms of further evaluation and/or treatment. For that reason, I suspect that I will discharge her from care for this particular incident at the time of her followup visit. ....

Id.

Petitioner testified that the following day, October 4, 2013, she could not get out of bed. Petitioner testified that she did not go to work from October 4, 2013 to October 8, 2013.

Petitioner testified that she then saw John O'Keefe, M.D. (Dr. O'Keefe) on October 8, 2013. The Central Medical Specialists[2] records reflect Petitioner's report on that date of bilateral wrist and low back pain as well as handwritten notes with the following history:

> went to move 60# box of paper that was above her head for the machine to make envelopes, felt her (R) hand give and the box fell off, patient fell into a seated position hitting buttox + using both hands to break her fall.

PX5 at 2. In a typed progress note of the same date, Dr. O'Keefe's physician's assistant, Lauren Kirsch, PA-C, noted the following history:

> Patient works as an envelope machine operator for Federal Envelopes. She is a 9-year veteran with this company and works 40+ hours weeks. Her job requires her to lift and place 50-60 lb. boxes about 15x an hour to fill the machine with paper. She was injured on 10/03/13 when she was moving a 60 lb. box that was stacked higher than her head to load it into the machine. She felt her right wrist give way as she was trying to move the box, causing her to lose balance. The box fell onto the cement floor to her left and she fell backwards onto her buttocks into a seated position. She used her two hands to break her fall on either side of her. Her supervisor, Mitch, helped her up. She verbally reported the incident to him and Kelly from HR immediately after. She was then seen by the company doctor. They took x-rays of the bilateral wrist which were read as negative for fracture. She was given 2 wrist braces for her wrists and

[2] The records of Dr. O'Keefe were procured from "Central Medical Specialists" as well as an entity known as "Marian Orthopedics & Rehabilitation." See PX5 & PX6.

> ibuprofen 200mg. She was then told to go back to work. At present, she has increased pain in her low back and bilateral wrist from the fall. She is unable to sleep due to pain. Patient has a history of gastritis. She also has a history of bilateral wrist tendinitis in 2011 that was treated by Dr. Vendor. She states her wrist pain was virtually resolved until the injury at work 10/03/13 re-aggravated those problems. She has no prior history of back pain or pathology.

PX5 at 161-162, 318-321; PX7 at 61-63. Ms. Kirsch diagnosed Petitioner with a low back sprain and bilateral wrist sprains post work injury on October 3, 2013. *Id.* She recommended physical therapy, which Petitioner then began at the Central Medical Specialists clinic. *Id.*

A handwritten phone call note that appears to be taken by one of Dr. O'Keefe's staff indicates that Kelly from Respondent's Human Resources department called. PX5 at 32. Among other notations, the handwritten note reflects Kelly's message that if Petitioner had restrictions they could be accommodated, that Petitioner was expected to return to work the following day at 3:00 p.m. as she had been released with no restrictions by the company clinic, and noting that the "Company is suspicious that she is truly injured and that her fall 'looked faked.' She says pt has a history of magnifying her sx + not being compliant with her wrist splints[.]" PX5 at 32.

On October 17, 2013, Petitioner returned to see Dr. O'Keefe. PX5 at 158-160, 194-195; PX7 at 58-60; PX28 (Dep. Ex. 3)[3]. Dr. O'Keefe noted the following history and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Patient is a 9-year veteran at Federal Envelope. She had a severe injury 10/03/13. Her supervisor Mitch witnessed it. He actually helped her up from the floor. Her job as a machine operator and envelope manufacturer requires that she work at a very rapid pace. 15x an hour she lifts 50-60 lb. loads. They stack boxes well above the height of her head with that load. On 10/03/13, she was up on her toes trying to shove a box mostly with her right shoulder up above her head (it was the 7th row). Her arm popped with pain. The box fell towards her chest, knocking her to the ground. She fell backwards onto the concrete with her arms hyperextended. She had intense pain in her back, right shoulder, and both hands at that point. The company doctor did see the patient that day and sent her back to work. She's had numbness and tingling in the hands since that time and weakness in the shoulder. She has left> right sciatica which is new since this injury. Unbelieveably, HR is calling us and telling us that they think she's malingering. From my perspective, she's concise, accurate, consistent, and honest. HR is saying they have light duty.
> ....

Id. He ordered an H-wave machine and recommended continued physical therapy. *Id.* Dr. O'Keefe also indicated that "**[i]t's my board-certified orthopedic opinion that the patient was intact and working as a heavy laborer for 9 years prior to this episode. She's never had back pain or sciatica. She's never had severe shoulder sprain.** The peripheral neuritic symptoms that she has at present are severe but hopefully will resolve with therapy and splints." *Id.* (**emphasis** in original).

On cross examination, Petitioner testified that she did not receive bills for the H-wave machine and she is not sure whether it was paid for through insurance. On the same day, Dr. O'Keefe's records reflect a call from Kelly in Respondent's Human Resources department that they had light duty work for Petitioner. PX5 at 135. The noted response was that Dr. O'Keefe did not release Petitioner to work because of her physical examination and clinical findings. *Id.*

---

[3] The physical examination findings, review of diagnostics, etc. presumably located on page two of the three page progress note was not submitted into evidence in any of the exhibits.

On October 30, 2013, Petitioner returned to Dr. O'Keefe. PX5 at 133, 156-157, 193-194; PX7 at 56-57. Dr. O'Keefe noted the following history and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Patient is a 9-year veteran at Federal Envelope and had a heavy, unprotected fall. She was knocked off of her feet by a 50-60 lb. box that struck her chest as she was trying to place it above the height of her head. She contused and sprained both arms in her spine. She's been off work despite HR's strong orders to return to work. **It's my board-certified orthopedic opinion that this woman was seriously hurt and has a discal injury in the L/S spine producing intense neuritis in the right > left leg at present. She has strong neuritic symptoms in both arms from the strain and contusion that she sustained from that injury 10/03/13.** She was intact and without debility or problems for the year prior as she worked with these heavy loads on a near constant basis.

Id. (**emphasis** in original). Dr. McAfee diagnosed Petitioner with a heavy, unprotected full spraining her spine on October 3, 2013, modest resolution of cervical spinal problems, persistent lumbar contusion and sprain with right greater than left sciatica at present as well as a sprain and strain of both hands with neuritic symptoms in both arms. *Id.* He ordered a lumbar MRI and therapy. *Id.* Dr. O'Keefe kept Petitioner off work. *Id.* Petitioner had an initial occupational therapy evaluation at Dr. O'Keefe's office on November 5, 2013. PX5 at 130-132.

In a letter dated November 14, 2013, Shalonda Lockett (Ms. Lockett), Sr. Claims Adjuster of Employers Preferred Insurance Company, requested that Petitioner complete and return a questionnaire and medical authorization form. PX5 at 98-103.

On November 26, 2013, Dr. O'Keefe PX5 at 134, 153-155, 193, 197; PX7 at 53-55. Dr. O'Keefe noted the following history in pertinent part:

> Patient had a work injury witnessed by her supervisor 10/03/13. She hurt her spine and has traumatic bilateral carpal tunnel symptoms, worse on the right than the left. She still having strong dysesthesias into the right arm from the neck and into the right leg from the lumbar plexus. ....
>
> The patient is an 8-year veteran at this jobsite and has had no history of spine problems or radicular symptoms until this severe, unprotected fall with a 60 lb. load smashing her into the concrete from a standing position. History for the carpal tunnel is positive for some treatment by Dr. Vender in the past but she's had years of function without the ability. This isn't a pre-existing condition. ....

Id. Dr. O'Keefe ordered a cervical MRI after a "heavy unprotected fall @ work 10/3/13" and continued occupational therapy. *Id.* He also noted that "[i]t's my board-certified orthopedic opinion that the patients had a trauma 10/13 produced spinal injury with disco injury in the cervical and lumbar area, producing peripheral neuritic symptoms of traumatic carpal tunnel and right > left sciatica." *Id.*

Petitioner returned to the occupational therapist at Dr. O'Keefe's office on December 3, 2013. PX5 at 128-129. The therapist noted that Petitioner had been diagnosed with a right wrist sprain with a "gradual onset[.]" *Id.* She recommended six weeks of therapy twice per week. *Id.*

Dr. O'Keefe ordered another EMG/NCV, which Petitioner underwent on December 4, 2013. PX5 at 125-127. The EMG/NCV showed no evidence of cervical radiculopathy or peripheral entrapment neuropathy. *Id.*

On December 23, 2013, Petitioner underwent an MRI of the cervical and lumbar spine. PX5 at 121-124; PX8 at 15-18. The interpreting radiologist noted degenerative disc disease at L4-5 with a moderate size disc protrusion and bony spondylitic changes with associated stenosis, mild-to-moderate L3-4 stenosis with left-sided asymmetric disc protrusion and narrowing left of the midline and mild levoscoliosis. *Id.* In the cervical spine, the radiologist noted mild disc bulging diffusely at C3-4 and C5-6 with mild vertebral endplate bony spondylotic changes. *Id.*

On December 31, 2013, Dr. O'Keefe referred Petitioner to his colleague at Central Medical Specialists, Krishna Chunduri, M.D. (Dr. Chunduri), to assess and treat her neck and low back injury at work in October of 2013. PX5 at 28, 148-151, 191-192; PX7 at 48-51. Dr. O'Keefe noted the following history from Petitioner and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Patient was hurt with a well-documented injury 10/13. She weighs 140 lbs. and throws 60 lb. loads above the height of her head 15x an hour. She's Been 9 years of that job site. She's not had spine problems prior. She had some wrist symptoms in 2011 but no interval wrist symptoms until she was hurt 10/13. **It's my board-certified orthopedic opinion that she may have had some wrist injury back in 2011 but it was the 10/13 injury that is causing her present debility and symptoms.** Certainly the mechanism of throwing a 60 lb. box above the height of her head causing electrical pain into the neck and right arm and a painful pop in the wrist is a suitable mechanism to produce a triangular fibrocartilage complex (TFCC) tear and a discal injury. The patient has abnormal MRI of the C-spine 12/13 showing discal traumatic bulge at C3-4 and C5-6 and abnormal MRI from Molecular Imaging 12/23/13 of the lumbar spine showing L4 and L5 bulging disc injuries. Electrical testing 12/04/13 is negative for radiculopathy in the neck and both arms.
>
> On questioning, it's her neck and right arm pain that are most disabling. She's been working with OT with a vast improvement from initial assessment 10/13 but she still having a high level of symptoms. She's only tolerating 2 lbs. resistance. I talked to OT today as I examined the patient and with us both here she's having mechanical popping with ulnar deviation and loading the risk.

Id. (**emphasis** in original). Dr. O'Keefe diagnosed Petitioner with a throwing injury above the height of her head with 60 lb. loads producing discal injuries in the neck and low back, right radiculitis secondary to the first diagnosis, and right wrist TFCC symptoms persisting. *Id.* He ordered occupational therapy twice a week. *Id.* Dr. O'Keefe also noted that he spoke with Kelly and that Petitioner's IME should assess her neck, low back, and bilateral hands. *Id.*

Petitioner also saw an occupational therapist at Dr. O'Keefe's office on January 9, 2014. PX5 at 119-120. The therapist noted that Petitioner had been diagnosed with a right wrist sprain with a "gradual onset[.]" *Id.* She recommended two weeks of therapy twice per week. *Id.*

Petitioner first saw Dr. Chunduri on January 22, 2014. PX5 at 170-171, 190. The medical records reflect that Dr. Chunduri is a board-certified anesthesiologist and pain management specialist. *Id.* Dr. Chunduri noted the following history from Petitioner and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Ms. Sanchez presents to the clinic with complaints of pain in her neck and mid-back, and lower back since her work injury 10/03/2013. She states she is a machine operator. She was placing a 50 lb. Box above her head when she suddenly felt pain in her neck and her arm. She was unable to securely placed the box which then fell down, causing her to fall onto her buttocks. She states that since his injury, she has been having throbbing, sharp, burning pain in her neck and her lower back. The neck pain she states

> radiates into her right upper extremity which feels numbness and tingling down her arm to her hand. She states that her low back pain radiates into her right buttock where she feels electric-like feeling in her upper thigh. She rates the pain as severe at 7/10. It is constant. It is worse in the mid-day and afternoon. It is worse with prolonged sitting, walking, lying down, and coughing. She states that standing makes it better. It affects her daily routine. She has been taking Meloxicam, Tramadol, and Prilosec and she has been in physical therapy.

Id. Dr. Chunduri diagnosed Petitioner with cervical spondylosis and cervicalgia as well as lumbar spondylosis and lumbago. *Id.* He prescribed a Medrol Dosepak, continued NSAIDs and continued physical therapy. *Id.* Dr. Chunduri also noted "[i]t is my opinion, based on a reasonable degree of medical certainty, that the above symptoms and diagnoses are causally related to the work injury and that the current treatments and recommendations are medically necessary." *Id.*

Petitioner returned to Dr. O'Keefe on January 28, 2014 solely for evaluation of the wrists noting that Dr. Chunduri was treating Petitioner for the low back. PX5 at 147, 189; PX7 at 47. He diagnosed Petitioner with resolving wrist sprains with poor ability to improve power. *Id.* He reduced physical therapy to once per week.

On February 6, 2014, Dr. Chunduri administered a right L4-L5 transforaminal epidural steroid injection. PX5 at 167-169. Petitioner testified that she remained off work as ordered by Dr. O'Keefe and Dr. Chunduri. On March 13, 2014, Dr. O'Keefe ordered continued physical therapy and requested authorization for epidural steroid injection into the lumbar spine and cervical spine. PX5 at 207; PX7 at 45-46.

On April 15, 2014, Dr. O'Keefe noted that Petitioner was 15 minutes late to her IME on January 6, 2014. PX5 at 139, 187, 206. She reported that her low back pain persisted, but was not as severe and that she continued to experience sciatica symptoms into the right leg. *Id.* She also reported continued bilateral wrist pain with less numbness in tingling into the digits. *Id.* Dr. O'Keefe ordered a series of 4-5 cervical epidural injections. PX5 at 137.

On May 15, 2014, Petitioner reported shooting pain from the right wrist to the elbow and mild low back pain. PX5 at 139, 142-143, 187, 206; PX7 at 42-44. Dr. O'Keefe noted that Petitioner "had a backward full heavily at work 10/13. She's been miserable with spine pain since." *Id.* He diagnosed an injury to the cervical and lumbar areas as a result of her heavy, unprotected fall at work in October of 2013 with abnormal MRIs from December of 2013 showing discal injuries. *Id.* Dr. O'Keefe also diagnosed Petitioner with bilateral carpal tunnel symptoms, right worse than left. *Id.* He indicated that Petitioner was miserable with neuritic symptoms, more in the neck then the low back and he recommended a trial of cervical epidural injections. *Id.* Dr. O'Keefe also indicated that he suspected that Petitioner's back would not be cured and she may need more of those injections in the future. *Id.* With regard to the carpal tunnel, Dr. O'Keefe indicated that it was partly being aggravated by Petitioner's cervical radiculitis and noted that he would hold off on advising surgery, but that she may need surgical release in the future. *Id.* He ordered continued use of the H-wave machine and physical therapy. *Id.*

Section 12 Examination – Dr. Weber

On May 19, 2014, Petitioner saw Dr. Kathleen Weber (Dr. Weber) at Respondent's request. RX1 (Dep. Ex. 2); PX5 at 92-97. Prior to this date, Petitioner testified that she had some appointments set with Dr. Weber, but she did not attend or she forgot to attend. On cross examination, Petitioner testified that she did not attend the prior

IMEs because on one occasion she spoke with her attorney at the time, and on another occasion it was 40 degrees below 0 and she got there 10 minutes late and Dr. Weber would not see her.

Dr. Weber's report indicates that she reviewed an incident report dated October 3, 2013 noting that "[t]he IE was raising a carton on top of a skid of boxes. The box was too heavy. The IE fell to the ground and injured both wrists and her lower spine." *Id.* Dr. Weber also reviewed the medical records of Dr. O'Keefe, Dr. Sisson, various utilization reviews and peer reports as well as Petitioner's May 7, 2014 lumbar MRI report. *Id.*

Petitioner reported to Dr. Weber through a translator that she had been a machine operator for nine years for Respondent and she had a prior bilateral hand repetitive trauma injury in 2011, but no prior low back injuries. *Id.* Dr. Weber noted the following history of accident:

> She states that on October 3, 2013, she was lifting a 50-pound box overhead, approximately 6-8 inches above her head. She felt right arm pain from her hand to her shoulder. The box began to fall and she tried to lift it back up but got dizzy and colleagues tried to help. Then, she states that she fell onto her buttocks. She is unsure if she had immediate back pain secondary to her dizziness. She caught herself with her hands. She was unable to stand and she was sent to the clinic. She states that following being evaluated at the clinic she went home. The next day she could not get out of bed, secondary to her whole back hurting. She did not return to the company clinic. She sought medical treatment with Dr. O'Keefe a couple of days later.

Id. Ultimately, Dr. Weber diagnosed Petitioner with bilateral wrist sprains and lumbar back sprain. *Id.* In so concluding, Dr. Weber noted that Petitioner's reported mechanism of injury changed within the medical records. *Id.* She opined that Petitioner's physical examination produced no objective findings or abnormalities, and determined that Petitioner's subjective complaints did not correlate with objective clinical findings on examination. *Id.* Dr. Weber stated Petitioner required no further care based on her normal exam, that she had reached maximum medical improvement, and had likely reached MMI within 4-6 weeks of the accident. *Id.* She stated Petitioner could return to work in a full duty capacity based on the normal exam. *Id.*

Utilization Reviews, Termination of Benefits & Continued Medical Treatment

The record reflects that Respondent obtained various utilization reviews dated May 6-8, 2014, July 10, 2014 and July 16, 2014. RX2-RX4; PX5 at 71-74; PX5 at 39, 44-46, 73. The reviews certified only 10 physical therapy sessions to the lumbar spine as of October 15, 2013 and 15 sessions to the bilateral wrists as of November 5, 2013. *Id.* The utilization reviews did not certify a series of cervical epidural injections recommended by Dr. O'Keefe, a prescription for Relafen, Tramadol, Dendracin, Prilosec, Mobic, Meloxicam, Omeprazole and Gabapentin. *Id.*

In a letter dated May 30, 2014, Shalonda Lockett (Ms. Lockett), Sr. Claims Adjuster of Employers Preferred Insurance Company, informed Petitioner's then-attorney that Petitioner's claim was being denied based on the independent medical evaluation report of Dr. Weber as well as the utilization reviews. PX5 at 91.

On July 8, 2014, Dr. O'Keefe noted the following: "[Petitioner] had a well-reported and documented injury 10/13. On that date, her normal duty was handling 50–60 lb. boxes, often above the height of her head. On such an occasion, the box slipped. She fell backwards heavily on both arms and landed on her rump on the ground behind her with this 60 lb. load falling. She had immediate pain in her spine and both arms." PX5 at 140-141, 185-186; PX7 at 40-41. Dr. O'Keefe diagnosed Petitioner with a lumbar discal injury with abnormal MRI as a

result of her injury at work in October of 2013. *Id.* He also indicated that Petitioner sprained and contused both arms. *Id.*

Petitioner underwent the updated EMG/NCV of the bilateral hands as well as of the low back on the following day, July 9, 2014. PX5 at 35-38; PX7 at 81-84; PX8 at 19-22. The results showed mild irritability present on EMG needle insertion at various muscles including those suggestive of L4-5 nerve root irritation. *Id.*

On August 7, 2014, Dr. O'Keefe noted that Petitioner was complaining of upper and lower spine pain, as well as bilateral arm pain, the month after her injury at work in October of 2013. PX6 at 37-38; PX5 at 136, 185. Among various other notations and opinions, Dr. O'Keefe indicated that "[w]e've been buried by work comp with a worthless chart review done 07/16/14 that completely neglects the abnormal electrical test and MRI." *Id.* Dr. O'Keefe ordered a series of four transforaminal steroid injections. *Id.*

As referred by Dr. O'Keefe, Petitioner first saw Ossama Abdellatif Hassan, M.D. (Dr. Hassan) on September 25, 2014. PX8 at 88-90, 94. Dr. Hassan noted the following history of accident in pertinent part:

> Rosa Sanchez is a patient that comes to us with lumbar spine pain and cervical spine pain due to a work related accident suffered on 10/3/13. Patient states while working as a machine operator for Federal Envelope Company as she was lifting boxes repetitively above head level on one occasion one box weighing approximately 50 pounds fell back on patient forcing her to take weight and fall to floor hitting buttocks and bilateral hands she report it (sic) injury as she noticed supervisor witnessed accident she went to company clinic attempted light duty work but was unable to do continue as pain had increased she has been off work since then she has undergone one previous injection in 2013 with positive response she continues to exhibit pain today nothing has been able to stabilize pain since date of injury ....

Id. Petitioner reported cervical pain that radiated into both upper extremities and low back pain radiating into both lower extremities. *Id.* Dr. Hassan primarily diagnosed Petitioner with lumbar radiculopathy lumbar facet syndrome as well as cervical radiculopathy with cervical facet syndrome and he made a tertiary diagnosis of myofascial pain. *Id.* He ordered a lumbar MRI, lower extremity EMG/NCV, lumbar epidural steroid injection, lumbar foraminal steroid injection, cervical MRI, upper extremity EMG/NCV, trigger point injection for myofascial pain and a work conditioning program followed by a functional capacity evaluation. *Id.* Dr. Hassan also imposed light duty restrictions including no sitting or standing more than two hours at a time. *Id.*

Petitioner testified that she attempted to return to work with these restrictions, but she went to work and she was told that they did not have a position for her. She explained that she saw Kelly Mueller in Human Resources and that she told Ms. Mueller that her doctor recommended that she return to work with restrictions including no standing or walking over two hours and no lifting over 20 pounds. Petitioner testified that Ms. Mueller told her that they did not have a position for her with those restrictions.

On September 11, 2014, Petitioner saw Dr. O'Keefe who noted the following history in pertinent part:

> Patient was heard with a well-reported and documented injury while working 10/13. A 50-60 lb. load cell from above the height of her head, forcing her hands into hyperextension. The load then made her fall backwards onto her rump, injuring her spine in the neck and low back. The hands took another blow at that point she tried to break the fall as she was falling back with her hands. We've been treating her for severe wrist sprains, worse on the right than the left, since she was first seen 5 days after the injury. She had a single injection 02/14 which was beneficial. That practitioner left our practice and we've not had authorization to proceed with further injections. My board-certified orthopedic opinion is that she

> has serious problems with her neck with discal injury evidence on MRI from 12/13 at the cervical C5-6 levels and in the lumbar L4-5 levels. She has abnormal electrical testing per Dr. Paly, M.D. 07/14 showing a right L4-5 radiculopathy. At this point I'm referring her to Dr. Hassan, pain management Dr., for assessment and treatment. ....

PX6 at 34-35. Dr. O'Keefe also noted that he received an IME from Dr. Weber dated May 19, 2014. *Id.* he indicated that the report only assessed Petitioner's low back and hands, although the patient asked Dr. Weber to assess the neck which she refused. *Id.* Dr. O'Keefe indicated that he disagreed with Dr. Weber's report noting that the exam took 20 minutes and the patient was not in a gown. *Id.* He also noted Dr. Weber's indication that Petitioner had no symptoms with TFCC provocative testing although Petitioner reported to him that she did tell Dr. Weber that it was painful when her wrist was put through range of motion. *Id.*

Dr. Hassan administered a trigger point injection, an epidural steroid injection and a sacral medial branch block in the low back on October 8, 2014. PX8 at 82-87. Petitioner returned to see Dr. Hassan on October 14, 2014 at which time he recommended bilateral radio-frequency ablation. PX8 at 77-81.

Petitioner underwent the recommended lumbar MRI on October 17, 2014. PX8 at 14. The interpreting radiologist noted disc herniations at L3-L4 and L4-L5 as well as mild spinal stenosis and bilateral neuroforaminal narrowing on the left at L4-L5. *Id.* Petitioner also underwent the recommended cervical MRI, which the interpreting radiologist noted showed a 1-2 mm posterior annular disc bulge at C5-C6 without spinal stenosis or significant neuroforaminal narrowing. PX8 at 13.

Petitioner then underwent the recommended radio-frequency ablation as well as an epidural steroid injection and trigger point injection on October 24, 2014. PX8 at 72-76. On October 30, 2014, Petitioner returned to Dr. Hassan who recommended another radio-frequency ablation into the lumbar spine. PX8 at 67-71.

On November 11, 2014, Dr. O'Keefe diagnosed Petitioner with a work-related sprain of the right wrist producing a traumatic DeQuervain's contracture of the right "1st ray" and distal forearm for which he ordered an ultra-sound guided cortisone injection. PX6 at 31-32. He also diagnosed Petitioner with a cervical and lumbar spinal injury with disc herniation per Dr. Hassan. *Id.*

Petitioner underwent the recommended radio-frequency ablation as well as an epidural steroid injection and trigger point injection on November 22, 2014. PX8 at 62-66. Petitioner testified that Dr. Hassan kept her off of work. Dr. Hassan's records reflect Petitioner's report on November 25, 2014 and January 20, 2015 that her lumbar condition had improved. PX8 at 54-61. He recommended proceeding with cervical injections. *Id.*

In the interim, on December 16, 2014, Dr. O'Keefe noted his "board-certified orthopedic opinion that [Petitioner] does have discal neck symptoms." PX6 at 28-30. He diagnosed Petitioner with a "[w]ell-documented injury at work, hurting her neck and low back with discal herniation seen from abnormal MRIs 12/13." *Id.* Dr. O'Keefe ordered a repeat cervical MRI and repeat EMG/NCV. *Id.* Petitioner underwent the cervical and bilateral upper extremity EMG/NCV on January 7, 2015. PX6 at 85-87. The results showed no evidence of cervical radiculopathy or peripheral entrapment neuropathy. *Id.*

Dr. O'Keefe also referred Petitioner to Mark Sokolowski, M.D. (Dr. Sokolowski) for assessment and treatment. PX9 at 4. Petitioner first saw Dr. Sokolowski on December 22, 2014. PX9 at 7-8. Petitioner reported neck pain with radiation to the right upper extremity, lumbar pain with radiation to the right lower extremity, left

hand pain and symptoms subsequent to a work injury. *Id.* Dr. Sokolowski noted the following history in pertinent part:

> ... [Rosa Sanchez] reports that she was in her usual state of health, and working in the course of her usual occupation, on October 3, 2013. Her job requires that she place envelopes into 60-pound boxes. She then lifts the boxes onto a skid. She reports that she was performing these duties, and lifting the boxes onto a skid stacked high enough that it was necessary for her to lift the box above eye level. As she lifted one such box of envelopes onto the skid, she developed shooting pain from her wrist through her right arm to her neck as well as left-sided hand pain. As the box started to slip, she lost her balance and fell backwards landing on her buttocks, catching herself on the ground with both arms. She reports that her supervisor saw her fall and came to assist her. She reported that she was very dizzy and unable to stand. ....

Id. Dr. Sokolowski reviewed Petitioner's cervical MRI of December 17, 2014. *Id.* He noted no large disc herniations. *Id.* Dr. Sokolowski also reviewed Petitioner's lumbar MRI from October of 2014. *Id.* He noted a central and left-sided disc herniation at L4-5 and an annular tear at L3-4. *Id.* Dr. Sokolowski diagnosed Petitioner with cervical pain and radiculopathy as well as lumbar pain and radiculopathy. *Id.* He ordered a cervical EMG to determine the etiology of Petitioner's symptoms versus peripheral entrapment process. *Id.* He also indicated that Petitioner was a candidate for a lumbar laminectomy from L3-5. *Id.*

On January 15, 2015, Petitioner returned to Dr. O'Keefe who noted the following history:

> Patient had a fall to the floor while working 10/03/13. She had shooting pain in the upper extremity as she held a 60 lb. load. She lost control of back and dropped back box which was about the height of her head. That knocked her off of her feet and she fell backward onto her arms, injuring her spine and both hands, right worse than left. We've tried to improve her with McKenzie and core strengthening exercises. She still having a high level of symptoms. She's had some pain management injections in the mid and low back with Dr. Hassan, M.D. in 2014. She's due to see him on 01/20/15. Dr. Sokolowski, M.D. assessed the patient and feels she is a candidate for some lumbar fusion needs because of this work injury. I saw the patient 12/14 and ordered a repeat MRI of the neck. That's not normal but it's not horribly abnormal. She had a repeat electrical test which was negative for neck and arm neuropathy. **It's my board-certified orthopedic opinion that she has traumatic discal injury in the next and it is causing clinical symptoms into the right arm and traumatic carpal tunnel symptoms.** We asked work comp. Several months ago for permission to do an ultrasound-guided cortisone injection. That's not been forthcoming. Will bring her back in the next week or two and do that as she's worsening and is very debilitated.

PX6 at 25-27 (**emphasis** in original). Dr. O'Keefe noted that electrical testing performed on January 7, 2015 for the neck and arm was negative for neuropathy/radiculopathy. *Id.* Petitioner's cervical MRI as noted by Dr. O'Keefe showed a mild herniation of the C5-6 disc with some thecal effacement and no apparent stenosis. *Id.*

On January 27, 2015, Petitioner returned to Dr. O'Keefe who noted that Petitioner had clinical evidence of a TFCC tear and traumatic carpal tunnel syndrome on the right. PX6 at 23-24. He also diagnosed Petitioner with DeQuervain's, traumatic carpal tunnel syndrome and a TFCC tear in the right wrist. *Id.* Dr. O'Keefe ordered a cortisone injection trial for the carpal tunnel syndrome or the DeQuervain's. *Id.*

On January 28, 2015, Dr. Hassan administered the recommended cervical medial branch block as well as an epidural steroid injection and trigger point injection. PX8 at 47-53. Petitioner returned to Dr. Hassan on February 3, 2015 reporting increased lumbar spine pain. PX8 at 43-46. He recommended a discogram and CT

scan as well as trigger point injection for myofascial pain as needed. *Id.* Dr. Hassan performed the recommended discogram and post-discogram CT scan the following day. PX8 at 10-12, 34-42. On cross examination, Petitioner testified that she was under anesthesia during the discogram.

On February 10, 2015 and March 5, 2015, Dr. Hassan recommended additional injections into the cervical spine and referred Petitioner for a surgical consult related to the low back. PX8 at 32-33. In the interim, on February 12, 2015, Petitioner underwent the recommended EMG/NCV. PX8 at 8-9. The radiologist noted the following history:

> The patient is a 48 year old female of (sic) with chief complaints of pain in her neck and lower back with pain, numbness and tingling in her arms and legs. She reports that 10/03/2013 she was at work lifting boxes and on one occasion she lifted a heavy box over her head when it came down on her, she fell back onto her knees and lower back. She had the immediate onset of pain in her neck and lower back pain, numbness and tingling in her arms and legs. She notes that she has been receiving care, with improvement; however, pain in her neck and lower back, with pain, numbness in tingling in her arms and legs persists. She noticed difficulty in sitting, bending and twisting. Her past medical history is unremarkable. ....

Id.

On February 26, 2015, Petitioner returned to Dr. O'Keefe who diagnosed traumatic carpal tunnel syndrome on the right. PX6 at 21-22. He ordered an ultra-sound guided cortisone injection to address DeQuervain's as well as another injection to address carpal tunnel syndrome if those symptoms did not improve. *Id.*

On March 31, 2015, Dr. O'Keefe ordered a repeat low back MRI. PX6 at 16-18. He noted that "**[i]t's my board-certified orthopedic opinion that the fall of 10/13 produced DeQuervain's symptoms in both wrists and peripheral neuritic symptoms in both arms which should be treated.** At this point, work comp. should authorize the ultrasound-guided injection of the 1st and 2nd dorsal compartments on the right. **Work comp. should authorize Dr.** Sokolowski's **request to perform spinal surgery.** She's miserable and can't work with those symptoms." *Id.* (**emphasis** in original). Dr. O'Keefe also reiterated that he reviewed Petitioner's IME report, with which he did not agree, and that the exam was not thorough. *Id.* He wrote a "prescription asking for her to have a genuine and thorough exam of her arms." *Id.* Petitioner underwent the recommended low back MRI on March 31, 2015. PX6 at 88. The interpreting radiologist noted L3-4 and L4-5 disc herniations that impinged the ventral margin of the dural sac. *Id.*

On April 10, 2015, Petitioner returned to Dr. Sokolowski. PX9 at 6. Petitioner testified that she knows that he reviewed her MRIs because she observed him reviewing her films. Dr. Sokolowski maintained his diagnoses and recommendation for a cervical EMG and lumbar laminectomy from L3-5. *Id.*

On April 14, 2015, Petitioner returned to Dr. Hassan who indicated that she was awaiting approval for surgery as recommended by Dr. Sokolowski. PX8 at 4-5, 26-28. He also recommended a surgical consultation related to the cervical spine. *Id.*

Dr. O'Keefe then ordered a right hand MRI, which was performed on August 8, 2015. PX6 at 64-65. The interpreting radiologist noted that the MRI showed a small wrist joint effusion, mild osteoarthritis most prominent in the first CMC joint, and was otherwise normal. *Id.*

Thereafter, from June 15, 2015 through September 29, 2015, Dr. O'Keefe has continued to recommend surgery to the right hand as well as the surgery recommended by Dr. Sokolowski to the low back. PX6 at 6-13. Petitioner last saw Dr. Hassan on August 18, 2015. PX8 at 1-3. He diagnosed Petitioner with cervical radiculopathy and cervical facet syndrome, lumbar radiculopathy and lumbar facet syndrome as well as myofascial pain. *Id.* Dr. Hassan maintained that Petitioner required a surgical consultation for the cervical spine, follow up with Dr. Sokolowski for the lumbar spine, and trigger point injections for her myofascial pain as needed. *Id.*

Deposition Testimony – Dr. O'Keefe

On November 12, 2015, Petitioner called Dr. O'Keefe as a witness and he gave testimony at an evidence deposition regarding Petitioner's medical treatment and his opinions. PX28. Dr. O'Keefe is a board-certified orthopedic surgeon. PX28 at 4-6, 72; PX28 (Dep. Ex. 1).

Dr. O'Keefe testified that traumatic carpal tunnel syndrome could occur if Petitioner fell heavily onto her wrists and he opined that she could have further torn a pre-existing TFCC tear causing an aggravation of the condition as a result of this mechanism of injury. PX28 at 14. He explained that even if Petitioner had a prior MRI showing a TFCC tear, she reported to him that she was functioning at a high level "hoisting up 60-pound boxes over her head, throwing them up over her head on her tiptoes 15 times an hour. You couldn't do that with a torn wrist." *Id.*, at 62-63. Dr. O'Keefe also opined that the treatment that he rendered to Petitioner was "absolutely connected" with her injury at work noting that she had been working for eight months before the injury without any problems. *Id.*, at 61-62, 64.

Dr. O'Keefe opined that the medications provided by Dr. Chunduri were indicated. *Id.*, at 45. Dr. O'Keefe also opined that the lumbar surgery recommended by Dr. Sokolowski was reasonable and necessary because "[w]e've had a cooperative patient that has tried therapy and medicines and restricted activity and injections, and she's not nearly good enough." *Id.*, at 58. He further opined that the treatment rendered by Dr. Hassan was reasonable and necessary. *Id.*, at 58-59. As of the date of his deposition, Dr. O'Keefe wanted to perform an arthroscopic "assessment" surgery of the sprain of the ulnar aspect of Petitioner's right wrist. PX28 at 59.

Dr. O'Keefe also disagreed with the opinions of Dr. Weber noting that she "doesn't have a real clue on this patient." PX28 at 65-66.

On cross examination, Dr. O'Keefe testified he performs surgery on "toes, fingers, hands, ankles, hips, knees," and that the spine is "the one I don't do." PX28 at 72. He testified half his patients have workers' compensation claims and that Petitioner found him through the "Hoya" newspaper[4]. *Id.*, at 72-73.

Dr. O'Keefe testified that Petitioner presented for a second opinion in April of 2013 reporting repetitive activity and treatment by Dr. Vender. PX28 at 73. He explained that Petitioner's bilateral wrist complaints from April of 2013 and October of 2013 were not the same. *Id.*, at 73-74. Dr. O'Keefe explained that "[t]he glaring difference is that she didn't have an explicit trauma for the treatment she had in 5 of '11. She did work activities. And I think she was told by Dr. Vender it was just kind of a repetitive use situation. But let me get to the actual note. I'm going for 4 of '13. Here we go. Cortisone injections that were beneficial, so she's just kind of asking what's going on and not saying I need surgery or anything. She's just saying, what do you think what

[4] *Hoy* is a Spanish language newspaper based in Chicago. http://www.vivelohoy.com/ (last visited May 10, 2016).

my physical exam is?" *Id.*, at 74. He maintained that Petitioner's bilateral hand symptoms were "[h]ugely" different in October of 2013 from those in April of 2013. *Id.*, at 75-76.

On cross examination, Dr. O'Keefe refused to directly respond to questioning about whether Petitioner had reached maximum medical improvement or if her condition had resolved between her visit in April of 2013 and her return to him in October of 2013. PX28 at 76-77. He explained that Petitioner had a mild overuse condition in April of 2013 and that he was not aware that Petitioner had a prior injury in April of 2013. *Id.* Rather, he testified that he did not know of a prior injury and that Petitioner had "so much trauma in October that that would have completely overwhelmed this April 13 assessment. She had mild symptoms there with no restrictions needed and not even for sure she needed medicines. When I saw her the first time, she's badly hurt and needs narcotic medicines and can't work. So I can't - - she was supposed to come back if she was having significant symptoms, at which I would feel more comfortable with them saying an injury in April of '13. I don't think it was an injury in April of '13 that I saw her for." *Id.*, at 77. Dr. O'Keefe further explained that Petitioner did not return to see him after April of 2013, which she was supposed to do, so he thinks she did well based on the lack of a follow up appointment. *Id.*, at 78-79.

Also on cross examination, Dr. O'Keefe testified regarding his physician's assistant's notations of the mechanism of injury and Petitioner's condition on October 8, 2013. PX28 at 80-83. He understood that Petitioner "was on her toes trying to push the box to stack it on the seventh row of a pallet...[a]nd it got hung up or hooked up and came back at her, hitting her in the chest and knocking her back onto her hands and her butt." *Id.*, at 80. He testified that the height of the box involved was significant because "she's probably not in very perfect balance[,]" she "is extremely extending" and the box at that height is "probably very capable of knocking her back onto her feet." *Id.*, at 81. Dr. O'Keefe also testified that the weight of the box as reported by Respondent was significant because a 50-60 pound box, or even a 40 pound box, would have been a third of Petitioner's body weight and enough to knock her off her feet. *Id.*, 79-80. With regard to a potential inaccuracy in Petitioner's accident history, Dr. O'Keefe explained that "[s]ome women don't know the right amount of a weight." *Id.*, at 98. Regardless, Dr. O'Keefe acknowledged that his physician's assistant's note of October 8, 2013 does not reflect a report by Petitioner that she injured her right shoulder, hyperextended her arms, or of any complaint of neck or right shoulder pain. *Id.*, at 81-83.

Dr. O'Keefe maintained that Petitioner had traumatic carpal tunnel syndrome, ulnar tunnel symptoms and a TFCC tear. *Id.*, at 86-89. He maintained that these diagnoses would be clinically diagnosed and that diagnostic tests, which in Petitioner's case were all negative, was unnecessary to accurately diagnose the conditions. *Id.* He maintained that Petitioner's symptoms were also caused by a cervical disc issue despite the lack of evidence of cervical radiculopathy or peripheral entrapment neuropathy at the time of Petitioner's cervical EMG in January of 2015. *Id.*, at 92-93.

Dr. O'Keefe was clearly and repeatedly asked what specific surgery or surgeries he recommended for Petitioner and what conditions such treatment was intended to address. PX28 at 94-95. In an evasive and generalized manner, he testified that "[w]e're putting in to do an arthroscopy of the wrist[,]" and that he was looking for perform an arthroscopic "assessment" of the TFCC tear and possibly, in two other surgeries, repair Petitioner's carpal tunnel syndrome and DeQuervain's syndrome. *Id.* He added, "[w]e would not - - this lady has got a complex problem here. She has carpal tunnel findings. What I would do is say, hey, Rosa, what is your worst symptoms right now, which of these three things. And I would try to go for that. But any of these things could be surgical and probably will. We'll probably work on one of them, have an improvement there, and then go to the next most-troublesome thing." *Id.*, at 95-96.

Continued Medical Treatment

On November 17, 2015, Petitioner returned to Dr. O'Keefe. PX6 at 4-5. He reiterated that Petitioner was hurt at work in October of 2013 and that she had severe mechanical symptoms in her right wrist. *Id.* Specifically, Dr. O'Keefe noted that "[w]e've asked to perform an arthroscopic procedure as an outpatient with probable open repair of the triangular fibrocartilage complex (TFCC) ligament. She has carpal tunnel symptoms and cubital tunnel symptoms on the ipsilateral side, even in the face of normal electrical testing. If we do the wrist scope and deal with the mechanical symptoms but the neuritic symptoms persist, she may well require nerve releases." *Id.*

Deposition Testimony – Dr. Sokolowski

On December 7, 2015, Petitioner called Dr. Sokolowski as a witness and he gave testimony at an evidence deposition regarding Petitioner's medical treatment and his opinions. PX29. Dr. Sokolowski is a board-certified orthopedic surgeon specializing in the spine. PX29 at 4-5; PX29 (Dep. Ex. 1).

Dr. Sokolowski testified that Petitioner's cervical and lumbar spine conditions as of Petitioner's first visit with him were causally related to her injury at work on October 3, 2013 based on the correlation between the event and onset of symptoms, the lack of pre-existing pathology in those regions, his physical examination findings and corroborative diagnostic studies. PX29 at 11-12. He maintained his opinions as of Petitioner's second visit on April 10, 2015. *Id.*, at 15-16. Dr. Sokolowski specifically opined that Petitioner's lumbar radiculopathy, disc herniation at L4-L5 and annular tear at L3-L4 were more likely than not caused by the incident at work. *Id.*, at 16-17. With respect to the neck, Dr. Sokolowski ordered an EMG, if one had not already been performed, as well as a lumbar laminectomy surgery. *Id.*, at 15-16.

On cross examination, Dr. Sokolowski testified that he believed the mechanism of injury described by Petitioner caused her cervical and lumbar findings. PX29 at 20-21. Specifically, he understood that Petitioner was extending a box weighing 60 pounds overhead and that she fell on her buttocks. *Id.* Dr. Sokolowski trusted Petitioner with regard to the reported history. *Id.*, at 21.

Dr. Sokolowski also testified that disc pathology in the cervical spine was not causing Petitioner's right arm symptoms. PX29 at 23. He explained that "[w]e have excluded disc pathology because I did not observe a herniation. Based on her symptoms, she more likely has peripheral entrapment." *Id.* Dr. Sokolowski also testified that the etiology of Petitioner's cervical symptoms was unclear. *Id.*, at 30.

With regard to the lumbar spine, Dr. Sokolowski testified that Petitioner's central findings were a probative cause of her central symptoms. PX29 at 26. He acknowledged that it was not typical for a left-sided herniation to cause symptoms on the right side, but he explained that Petitioner had central and left-sided herniation so there was a reasonable expectation of bilateral nerve root involvement. *Id.*, at 27. Dr. Sokolowski acknowledged that Petitioner had pre-existing pathology (i.e., disc desiccation) at L3-L4 and L4-L5. PX29 at 28.

Continued Medical Treatment

On December 31, 2015, Dr. O'Keefe indicated that Petitioner had a severe right wrist sprain from her work injury in October of 2013 with an abnormal MRI showing a TFCC injury, which was tremendously alleviated for a few hours after an ultra-sound guided cortisone injection. PX6 at 3. Dr, O'Keefe noted that "**[t]his**

patient needs to have the outpatient arthroscopic procedure performed. There is little I can do to get her back to being functional as a worker who is supposed to handle 50-60 lb. loads when she has a torn ligament in her wrist that's causing painful weakness and arc of motion. Work comp. needs to authorize this immediately or else set her up with a new IME with a hand surgeon to assess this genuine and severely injured patient after the work injury of 10/13." *Id.* (**emphasis** in original). He kept Petitioner off work. *Id.*

Deposition Testimony – Dr. Weber

On January 13, 2016, Respondent called Dr. Weber as a witness and she gave testimony at an evidence deposition regarding Petitioner's conditions and the relatedness, if any, of her conditions to an injury at work. RX1. Dr. Weber is board-certified in internal medicine and sports medicine. RX1 at 5-8; RX1 (Dep. Ex. 1).

Dr. Weber explained Petitioner's back examination was within normal limits with the exception of subjective complaints with lumbar range of motion, and had no neurologic abnormalities. RX1 at 13. She did not diagnose lumbar radiculopathy because Petitioner exhibited no symptoms which suggested neural tension, such as a straight leg or cross leg raise, and a negative slump. *Id.*, at 15. Dr. Weber stated that although Petitioner reported some decreased sensation in the distal right thigh, the exam was normal. *Id.*, at 15-16. Dr. Weber also reviewed Petitioner's low back MRI report noting degenerative changes in the lumbar spine, which were not symptomatic at the time of her examination. *Id.*, at 13, 26.

Dr. Weber testified that she reviewed Petitioner's bilateral wrist MRI reports, which suggested chronic scapholunate abnormality and preexisting degenerative changes. RX1 at 13, 26. Dr. Weber explained she did not diagnose a TFCC tear because Petitioner had no tenderness over the TFCC and provocative testing of the TFCC did not reproduce any symptoms. RX1 at 14. Though Petitioner had MRI findings at the scapholunate, her physical exam yielded no scapholunate pain or instability. *Id.* Dr. Weber also testified that she did not diagnose carpal tunnel syndrome because Petitioner "had no findings that would suggest carpal tunnel in the sense that she had negative Tinel's and negative Phalen's bilaterally at the wrist[]" with no evidence of atrophy. *Id.* Dr. Weber further explained she did not diagnose Petitioner with DeQuervain's syndrome because Petitioner did not have an unequivocal Finkelstein's and because the mechanism of injury described by Petitioner would not have caused it. *Id.*, at 14-15.

Ultimately, Dr. Weber maintained that Petitioner's presentation was wholly subjective and did not correlate to any objective findings. RX1 at 15-16. "Based on the described mechanism of injury it appeared that she more probable than not sustained a mild wrist and lumbar back strain." *Id.*, at 16. Dr. Weber testified that "there is a suggestion of non-physiological causes for ongoing subjective complaints as her exam was normal." *Id.*, at 22. Dr. Weber testified that the accident as described by Petitioner did not aggravate any pre-existing scapholunate or degenerative lumbar spine findings. *Id.*, at 18.

Dr. Weber testified that a reasonable course of treatment for Petitioner's condition resulting from the October 3, 2013 accident would have been a short course of physical therapy and medications lasting 4-6 weeks. RX1 at 19-20. She explained that injections were not necessary because there was nothing in the record to suggest any true radicular-type symptoms. *Id.*, at 29. She also explained that epidural injections are not indicated for numbness, but rather for radicular type symptoms, and she noted that the Central Medical Specialists records showed nothing to suggest positive straight leg raises or slump tests. *Id.*, at 20. Dr. Weber testified that Petitioner had a normal exam and no further medical treatment was necessary. *Id.*, at 21.

On cross examination. Dr. Weber testified that if Petitioner fell backwards on her buttocks and hands she could aggravate a TFCC tear, increase a scapholunate tear and increase symptoms in the lumbar spine. RX1 at 26-27. Dr. Weber acknowledged that she did not evaluate Petitioner for a cervical spine condition. *Id.*, at 27.

Continued Medical Treatment

Petitioner testified that she has continued to see Dr. O'Keefe through March 31, 2016 and he has continued to keep her off of work. On March 31, 2016, Dr. O'Keefe continued to recommend surgery to repair a right wrist TFCC tear and requested authorization of the back surgery recommended by Dr. Sokolowski. PX7 at 1-2. He noted the following in pertinent part:

> ... [Petitioner] was hurt so badly in 10/13 that she wasn't able to go back without restrictions. We did try to have her go back but work wouldn't have her. She's been a very compliant patient on maximum doses of medications, including NSAIDs, Aciphex, Hydrocodone, and Neurontin. She had gastric symptoms and even had an endoscopy which that doctor said was probably related to the prescription medicines we've been providing. **Ideally we'd be allowed to do the surgery so that we wouldn't be trying to suppress these high symptoms with medications. Work comp. should authorize the requested surgeries ASAP (the back surgery with Dr.** Sokolowski, **M.D. was requested 04/15 and the right arm surgery was requested 08/15). It's my board-certified orthopedic opinion that the patient was hurt with work activities 10/13 and had a back injury and discal symptoms with right radiculitis which should be authorized for Dr.** Sokolowski **to performing back surgery on.** Her right arm remains problematic with numbness and tingling in the ulnar and median nerves. We asked for ultrasound-guided cortisone injection of the wrist back in 08/15. That occur from a 7/10 level to a 0/10 for a brief time. The triangular fibrocartilage complex (TFCC) ligament needs to be addressed with arthroscopic exam as requested 08/15.

Id. (**emphasis** in original). Petitioner testified that she wishes to undergo the surgery recommended by Dr. O'Keefe and the low back surgery as recommended by Dr. Sokolowski.

Prior to October 3, 2013, Petitioner testified that she did not have any low back problems. She also testified that she has not had any accidents thereafter. On October 13, 2012, Petitioner testified that she was involved in a motor vehicle accident and she underwent CT scans of her neck and her thorax and chest. She also had CT scans of her abdomen and hips. She was treated and released from the emergency room on that date, but did not have any further follow up care thereafter as a result of her accident.

Regarding her current condition, Petitioner testified that she does not engage in any activities at 100%. She explained that this is due to her right wrist pain and her low back pain. While walking, Petitioner testified that her whole right side becomes numb, her right knee does not allow her to descend stairs easily and her right big toe is always numb. Petitioner explained that she can walk for about 15 minutes before her pain starts.

While ascending or descending stairs, Petitioner testified that there is no time when she does not feel pain in her right knee. Petitioner described that she has to adjust her right knee when she ascends or descends stairs because she does not have strength. She also has low back pain and she cannot sit for long periods of time in one position or any position. Petitioner testified that, at the time of the hearing, she had been sitting for over an hour and 15 minutes and she felt a lot of pain in the right buttock and low back.

With regard to her right hand, Petitioner testified that her fingers become numb. She experiences pain and feels cracking with movements of the right wrist such as while using a knife, washing dishes, or stirring food while

cooking. Petitioner testified that she uses a wrist brace on both wrists at night and she uses a brace on her right wrist most of the time. Petitioner takes Tylenol and pain medication prescribed by Dr. Smith, her primary care physician, for her right wrist pain sometimes three times per day.

On cross examination, Petitioner testified that Dr. Smith told her that the medications are for her nerves, but she could not recall the names of the medications. She also testified that her right hand pain is now stronger than it was in 2011 and she has different symptoms in the left hand compared to the right hand. On the left, Petitioner testified that she feels wrist pain, but no numbness in the fingers. Petitioner testified that she has not had any subsequent accidents to her hands.

Mitchell Silva

Respondent called Mitchell Silva (Mr. Silva) as a witness. Mr. Silva testified that he is currently employed by Respondent as a Plant Manager and has worked there for 15 years. Mr. Silva oversees all three shifts, primarily overseeing machines.

Mr. Silva testified that Petitioner was a second shift Operator. He explained that Petitioner's main responsibility was to check quality and pack envelopes inside cartons measuring 21¼ x 12¼ x 9⅞ that weighed an average of 30 pounds when full. Mr. Silva testified that he knew the dimensions and weight of these boxes because he ordered 20,000 every month. Mr. Silva testified that Petitioner was to place filled boxes onto pallets and complete a production sheet with totals for the day. Pallets held 36 cartons and were stacked six cartons wide and six cartons high. Each full pallet measured about 54 inches tall including the height of the pallet, which is 4-5 inches. Mr. Silva testified that the cartons were not supposed to be stacked seven cartons high because the weight would crush the bottom cartons.

On October 2, 2013, Mr. Silva testified that he was working with Petitioner and he observed the alleged accident. He explained that he was walking toward her machine and noticed her pick up a box and walk toward a center aisle. She lifted the carton chest high on the skid, paused, then awkwardly and slowly went down to her left side and made a quick yelp. He testified that Petitioner landed on her left wrist and elbow. Mr. Silva testified that Petitioner was putting the box onto the fifth level of boxes on the skid at approximately chest height at the time of this incident and that he was only 10 feet from her when he witnessed the incident.

Mr. Silva testified that he asked Petitioner if she was ok and she grabbed her right wrist and elbow. Although he testified that he saw Petitioner land on her left wrist and elbow, Petitioner told him that she fell on her right wrist and elbow. Mr. Silva testified that he did not recall helping Petitioner up from the floor.

Mr. Silva then reported the accident to Kelly Mueller (Ms. Mueller) in the Human Resources department. Mr. Silva told Ms. Mueller that there was an incident where an employee said she was hurt. He testified that Petitioner landed on her butt and her left hand was down and when he went over to her she was holding her right hand. He did not observe her on her right hand and he did not observe Petitioner's right hand hit the ground.

Respondent offered into evidence a compilation of photographs taken by Mr. Silva of the pallet involved in the incident from different angles. RX7. Mr. Silva testified that these photographs were taken the day after the incident.

On cross examination, Mr. Silva testified that the photographs show the pallet stacked five cartons high and he explained that a pallet can be stacked up to six cartons high. He testified that each carton weighed about 30 pounds. He testified that, if someone is only 5'2 tall, that person would not have to lift a carton over shoulder level to get it onto the fifth level of cartons. Mr. Silva testified that he actually observed Petitioner putting the box up on the pallet. He explained that he was looking at Petitioner from her left side. He explained that Petitioner put the box on the pallet, hesitated and then fell. He also testified that he did see where Petitioner's right hand was during this incident. Mr. Silva explained that he observed Petitioner the entire time and he maintained that Petitioner put the box on the pallet, hesitated, and then fell. He explained that Petitioner did not exhibit any pain symptoms. He also testified that the box that Petitioner was lifting did not fall.

Rebuttal Testimony of Petitioner

Petitioner testified that she is 5'2 tall and that the boxes photographed in Respondent's Exhibit 7 are like the boxes with which she was working. Petitioner testified that on October 3, 2013 she is sure that she was stacking boxes seven levels high and the box that she was stacking was over her head at the seventh level.

ISSUES AND CONCLUSIONS

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

In support of the Arbitrator's decision relating to the admissibility of Respondent's Exhibit 9, the Arbitrator finds the following:

Petitioner objected to the admissibility of Respondent's Exhibit 9 based on either lack of foundation or the hearsay nature of the exhibit. Petitioner's objection on the basis of foundation is overruled. Petitioner's objection on the basis of the hearsay nature of the exhibit is sustained. Respondent's Exhibit 9 is a prior consistent statement. Respondent's Exhibit 9 is not admitted into evidence, but will remain with the Commission's file as a rejected exhibit.

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the accident at work, the Arbitrator finds the following:

In this case, Petitioner claims that she sustained a repetitive trauma injury manifesting on May 4, 2011. The fact that Petitioner sustained such an accident at work is not disputed. See AX1. Petitioner claims continued causal connection between her accident on May 4, 2011 and her current condition of ill-being based on an intervening, aggravating accident at work occurring on October 3, 2013. Petitioner's claim for benefits related to the claimed October 3, 2013 accident is addressed in the concurrent decision issued in Case No. 13 WC 37473. With regard to her May 4, 2011 accident, the Arbitrator finds that Petitioner's bilateral wrist condition is causally connected to the injury through her last visit with Dr. Vender on May 3, 2012.

On May 4, 2011, Petitioner received care at the company clinic with Dr. Bender and other doctors or physicians' assistants. She was given a wrist splint for each hand and placed on light duty restrictions. Petitioner then underwent bilateral wrist MRIs, which the interpreting radiologist noted to show a scapholunate ligament sprain with focal signal abnormality by its scaphoid attachment suspicious for partial thickness tear on the left and a high grade partial tear of the scapholunate ligament on the right. These MRIs were reviewed by Dr. Ostric who indicated that he was "not concerned that she has a pathology in her wrist. These are all normal changes with aging such as the partial tear of the scapholunate, ligament and the lunate cyst." Dr. Ostric believed that Petitioner might have carpal tunnel syndrome and ordered an EMG, which Petitioner underwent and showed no evidence of bilateral median neuropathy, ulnar neuropathy or cervical radiculopathy.

After Petitioner was released from care at the clinic on July 12, 2011, she saw Dr. Hill at Illinois Bone and Joint. He also reviewed Petitioner's test results and diagnosed Petitioner with chronic bilateral upper extremity pain and paresthesias of uncertain etiology. Dr. Hill disagreed with Dr. Ostric and noted that Petitioner's clinical presentation did not suggest carpal tunnel syndrome or ulnar neuritis. He believed that Petitioner could be experiencing some form of atypical cervical radiculopathy or even inflammatory arthropathy. He ordered a cervical MRI, which was normal.

Dr. Sisson of the company clinic noted that Petitioner underwent conservative treatment and diagnostic testing with bilateral wrist MRIs showed a "high-grade partial tear of the scapholunate ligament[, and the] results for the left wrist showed a scapholunate ligament sprain that was suspicious for a partial-thickness tear." He also noted that "[o]n July 29, 2011, [Petitioner] returned with complaints of having injured her wrist and neck while

lifting a sack of garbage. At that time, conservative treatment was instituted and she was again discharged from our care."

Petitioner then saw Dr. Vender on September 12, 2011 who diagnosed bilateral tenosynovitis. He also ordered a second set of EMG/NCV tests, which were performed on the same day. The results were normal. Petitioner returned to see Dr. Vender and received several injections with no reported relief. Then on December 1, 2011, Petitioner reported left elbow complaints for the first time. Dr. Vender diagnosed bilateral tenosynovitis and medial epicondylitis and administered an injection into the left elbow. Dr. Vender ordered occupational therapy, which Petitioner underwent. He indicated that as of February 20, 2012, no aggressive treatment was recommended for Petitioner's multiple upper extremities complaints and he ordered a home exercise program.

In the interim, Petitioner was involved in a motor vehicle accident. She testified that this accident did not aggravate her condition in any way. The medical records reflect that Petitioner was diagnosed with a neck sprain and sent home. When Petitioner returned to Dr. Vender on May 3, 2012, he noted that he discussed Petitioner's bilateral wrist pain and diffuse upper extremity, neck and shoulder complaints with Petitioner and her daughter. Dr. Vender indicated that "There has been difficulty with the location and consistency of complaints and findings. Would recommend followup. With her primary physician or possibly a rheumatologist."

However, Petitioner did not undergo further medical treatment for any condition for 11 months until she saw Dr. O'Keefe on April 9, 2013 for a second opinion related to the bilateral wrists. The Arbitrator finds sufficient evidence that Petitioner had reached maximum medical improvement as of May 3, 2012 when she was released by Dr. Vender as it is followed by this gap in treatment, particularly after she had been referred for follow up with either her primary care physician or a rheumatologist. Notwithstanding, Dr. O'Keefe's testimony about Petitioner's April 9, 2013 visit further supports the proposition that Petitioner's bilateral wrist condition had resolved long before she saw him or sustained her claimed second accident at work.

Dr. O'Keefe testified that Petitioner presented for a second opinion in April of 2013 and took pains to explain that Petitioner's bilateral wrist complaints from April of 2013 and October of 2013 were not the same. Indeed, he went so far as to add that "[t]he glaring difference is that she didn't have an explicit trauma for the treatment she had in 5 of '11. She did work activities. And I think she was told by Dr. Vender it was just kind of a repetitive use situation. But let me get to the actual note. I'm going for 4 of '13. Here we go. Cortisone injections that were beneficial, so she's just kind of asking what's going on and not saying I need surgery or anything. She's just saying, what do you think what my physical exam is?" He maintained that Petitioner's bilateral hand symptoms were "[h]ugely" different in October of 2013 from those in April of 2013. Dr. O'Keefe also specifically explained that Petitioner did well based on the lack of a follow up appointment with him after April 9, 2013.

As it relates to Petitioner's May 4, 2011 repetitive trauma accident, Dr. O'Keefe's testimony supports the conclusions of Dr. Sisson and Petitioner's own treating physician, Dr. Vender, that Petitioner's conservatively treated bilateral wrist condition had resolved long before her claimed accident at work on October 3, 2013. Based on all of the foregoing, the Arbitrator finds that Petitioner's condition of ill-being resolved as of her last visit with Dr. Vender on May 3, 2012.

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:

Petitioner claims entitlement to payment of reasonable and necessary medical bills from medical providers that administered care after her accident at work on May 4, 2011. The medical bills submitted into evidence relate to immediate care at the company clinic, hospital services, diagnostic testing, physicians' services, physical therapy and prescription medications prescribed as a direct result of her injury at work. Based on the exhibits, it appears that all of the medical bills through May 3, 2012 have been paid pursuant to the fee schedule and Sections 8(a) and 8.2 of the Act. Petitioner has also placed into evidence medical bills for care administered at Northwestern Community Hospital on and after March 13, 2012 for treatment subsequent to a motor vehicle accident. These bills are clearly unrelated to Petitioner's May 4, 2011 work accident and the bills found in Petitioner's Exhibit 10 are specifically denied.

Based on all of the foregoing, the Arbitrator denies Petitioner's claim for payment of additional medical expenses beyond those paid by Respondent for treatment through May 3, 2012, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment for any medical bills related to the motor vehicle accident on March 3, 2012 is specifically denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSA MARIA SANCHEZ,

Petitioner,

vs.

NO: 13WC 37473

18IWCC0298

FEDERAL ENVELOPE COMPANY,

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 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 May 11, 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.

18IWCC0298

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: MAY 9 - 2018
o032018
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

SANCHEZ, ROSA MARIA
Employee/Petitioner

Case# **13WC037473**

11WC025277

FEDERAL ENVELOPE COMPANY
Employer/Respondent

18IWCC0298

On 5/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% 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:

1922 STEVEN B SALK & ASSOCIATES LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0210 GANAN & SHAPIRO PC
JOSEPH P BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 60654

18IWCC0293

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) & 8(a)

Rosa Maria Sanchez
Employee/Petitioner

Case # **13** WC **37473**

v.

Consolidated cases: **11** WC **25277**

Federal Envelope Company
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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Wheaton (for Elgin)** on **April 12, 2016**, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **October 3, 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 as explained *infra*.

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

Petitioner's current condition of ill-being *is in part* causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned **$17,680.00**; the average weekly wage was **$340.00**.

On the date of accident. Petitioner was **46** years of age, *single* with **no** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services as explained *infra*.

Respondent shall be given a credit of **$4,490.73** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,490.73**.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner did sustain an accident at work on October 3, 2013 as claimed to the extent opined by Respondent's Section 12 examiner, Dr. Weber.

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits of $237.67/week for 364 & 2/7th weeks, commencing October 4, 2013 through November 13, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from October 3, 2013 through March 12, 2016, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be entitled to a credit of Petitioner's $4,490.73 for temporary total disability benefits paid.

Medical Benefits

Respondent shall pay the reasonable and necessary medical services related to the bilateral wrist sprains and low back sprain through November 13, 2013 as reflected in Petitioner's Exhibits as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of any other medical bills is denied.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator denies the prospective medical care recommended by Dr. O'Keefe and Dr. Sokolowski.

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 11, 2016
Date

MAY 11 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Rosa Maria Sanchez
Employee/Petitioner

v.

Federal Envelope Company
Employer/Respondent

Case # **13** WC **37473**

Consolidated cases: **11** WC **25277**

FINDINGS OF FACT

The parties appeared for a consolidated trial in the above captioned cases. The issues in dispute in this case include whether Petitioner sustained a compensable accident on October 3, 2013, causal connection, Respondent's liability for payment of certain medical bills, Petitioner's entitlement to temporary total disability benefits commencing October 4, 2013 through April 12, 2016 as well as Petitioner's entitlement to prospective medical care. Arbitrator's Exhibit[1] ("AX") 2. The issues in dispute in Case No. 11 WC 25277 include causal connection and Respondent's liability for payment of certain medical bills, which are addressed in a concurrent decision issued in that case. AX1. The parties have stipulated to all other issues. AX1 & AX2.

May 4, 2011

Rosa Maria Sanchez (Petitioner) testified that she was employed as a Machine Operator by Federal Envelope Company (Respondent) on May 4, 2011 and she had been so employed for six years. Petitioner explained that she packed envelopes that came out of a machine into boxes all day. Envelopes would come out of the machine in horizontal stacks of 2,400 envelopes. Petitioner explained that some of the envelopes would stick up and she would have to push them down to even out the stack. Petitioner testified that she would compress the stack of envelopes together and turn the stack of 2,400 envelopes over to place them in a box located to her left side. When the box was filled with envelopes, Petitioner would close the box and put it through a taping machine. After the box was closed, Petitioner would put the box down on a skid. She estimated that each box weighed about 60 pounds.

Petitioner testified that she compressed stacks of envelopes and turned them over many times throughout her eight hour shift per day. She explained that she did this for six years before May 4, 2011. Petitioner is right hand dominant.

On May 4, 2011, Petitioner testified that her hands started to hurt. She had experienced pain for a couple of months before this date. She felt a burning sensation in both wrists that went up to her elbows, but more on the right. Petitioner explained that the pain did not allow her to sleep.

On cross examination, Petitioner testified that she had bilateral wrist pain as well as numbness in her thumb, index finger, ring finger and pinky finger. Petitioner testified that she noticed pain when using her wrists to turn envelopes over and when lifting boxes to lift them up.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)."

On May 4, 2011, Petitioner spoke with her supervisor, Dean, and reported that she could not work anymore because she had pain in her hands. She testified that her pain was very strong and explained that she could no longer work. Petitioner estimated her pain at a level of 6 or 7 out of 10 while she was packing envelopes. She testified that Dean sent her to Kelly in the Human Resources department and, thereafter, she was sent to Advanced Occupational Medicine and saw Dr. Sandra Bender (Dr. Bender).

Medical Treatment

On May 4, 2011, Petitioner testified that she saw Sandra Bender, M.D. (Dr. Bender) at Advanced Occupational Medicine. PX6 at 9-10. She was given a wrist splint for each hand and placed on light duty restrictions. *Id.* Petitioner testified that she then returned to work on May 5, 2011. On cross examination, Petitioner testified that she returned to light duty without repetitive work and no lifting over a certain amount of pounds. While she was no longer performing repetitive activities, Petitioner testified that the pain was less, but still at night she felt pain.

On May 27, 2011, Petitioner testified that she returned to Advanced Occupational Medicine. Bilateral wrist MRIs were ordered. PX6 at 10. On June 2, 2011, Petitioner underwent the recommended MRIs. PX2 at 21-24. The interpreting radiologist noted a scapholunate ligament sprain with focal signal abnormality by its scaphoid attachment suspicious for partial thickness tear on the left and a high grade partial tear of the scapholunate ligament on the right. *Id.*

Petitioner testified that she returned to Dr. Bender on June 9, 2011. The medical records reflect that Jacey Howard, PA-C, referred Petitioner to Srdjan (Andrei) Ostric, M.D. (Dr. Ostric). PX6 at 6. Ms. Howard noted "[bilateral] wrist pain presented [with] s/s DeQuervains, Tx [with] PT/splints [without] improvement. MRI on 6/2 revealed [left] partial tear/sprain of scapholunate & tear of [right] scapholunate. NSAIDs and phys therapy continued [without] improvement in pain (8/10) please eval & tx." PX6 at 6.

On June 16, 2011 Petitioner saw Dr. Ostric at Midwest Plastic & Reconstructive Surgery. PX1. Dr. Ostric noted the following history:

> Ms. Sanchez is a 43-year old right-hand dominant female who complained of pain early January 2011 and it has progressed over the past several months to the point where she is having difficulty at work. She works as a machine operator packaging envelop[e]s into boxes and it requires overhead lifting and significant use of her hands. She has been doing this for approximately six years. She is otherwise, healthy and I know she is taking anti-inflammatory medications, which you prescribed to her. I did review the MRIs. I am not concerned that she has a pathology in her wrist. These are all normal changes with aging such as the partial tear of the scapholunate, ligament and the lunate cyst.

Id. He noted that Petitioner's physical examination was more consistent with carpal tunnel syndrome and he ordered bilateral EMG/NCVs and prescribed physical therapy. *Id.* Petitioner remained on light duty work restrictions. *Id.*

On July 8, 2011, Petitioner underwent the recommended EMG/NCVs. PX4 at 41-43; PX6 at 2-5. The results included no evidence of bilateral median neuropathy, ulnar neuropathy or cervical radiculopathy. *Id.*

On July 8, 2011, Petitioner saw Priti Khanna, M.D. (Dr. Khanna) at Advanced Occupational Medicine Specialists. PX6 at 5. Dr. Khanna noted "repetitive work – started having pain in both hands [left] [illegible]

greater than the right now R>L. Numbness [bilateral] hand [bilateral] thumb, index & [right] ring at times. Numbness intermittent [without] nocturnal paresthesias [positive] weakness [R>L] [positive] neck pain [into] right shoulder & [without left] radicular pain in [positive left] elbow + forearm[.]" *Id.* Dr. Khanna reviewed Petitioner's EMG/NCV which showed no evidence of bilateral median neuropathy, ulnar neuropathy or cervical radiculopathy. *Id.* On July 12, 2011, Petitioner was released from care. PX6 at 10.

On July 29, 2011, Petitioner testified that she returned to Dr. Bender after an incident at work lifting garbage. See also PX6 at 10. Petitioner testified that Dr. Bender provided some conservative treatment then released her from her care and then referred her to Dr. Hill at Illinois Bone and Joint.

On August 1, 2011, Petitioner saw James Hill, M.D. (Dr. Hill) at Illinois Bone and Joint. PX2 at 2-3. He noted Petitioner's reported "longstanding history of bilateral upper extremity pain and paresthesias." *Id.* Petitioner reported "that she began to notice discomforts in her upper extremities bilaterally beginning May 2011. She feels that her right upper extremity is slightly more affected than the left. She attributes the onset of her symptoms to the repetitive requirements of work-related activities as a machine operator." *Id.*

Dr. Hill noted his review of Petitioner's bilateral EMG/NCV test results which showed partial, bilateral scapholunate tearing. PX2 at 2-3. He diagnosed Petitioner with chronic bilateral upper extremity pain and paresthesias of uncertain etiology. *Id.* Dr. Hill also indicated that Petitioner's clinical presentation did not suggest carpal tunnel syndrome or ulnar neuritis. *Id.* He believed that Petitioner could be experiencing some form of atypical cervical radiculopathy or even inflammatory arthropathy. *Id.* Dr. Hill ordered a cervical MRI and seriologic work-up. *Id.* On August 17, 2011, Petitioner underwent the recommended cervical MRI, which was normal. PX2 at 20.

Petitioner testified that she then saw Michael Vender, M.D. (Dr. Vender) on September 12, 2011 as referred by her prior attorney. The medical records reflect Petitioner's report of bilateral hand symptoms since May of 2011 including intermittent numbness in the thumbs and index fingers, a feeling of weakness and wrist pain into the palm. PX2 at 29-31; PX4 at 14-17, 35-36. Dr. Vender diagnosed Petitioner with bilateral tenosynovitis and administered a steroid injection into the right wrist. *Id.* He also ordered a second set of EMG/NCV tests, which were performed on the same day by Scott Heller, M.D. (Dr. Heller). PX4 at 37-38. Dr. Vender noted that the results were normal. *Id.*

Petitioner returned to see Dr. Vender on September 26, 2011 and he administered an injection into the left wrist. PX4 at 12-13, 33-34. On October 20, 2011, Dr. Vender noted that Petitioner did not respond to the injection and she was experiencing more pain and numbness, more prominently on the right. PX4 at 11, 32. She testified that she had bilateral wrist pain at this time while she was working and turning envelopes over and that she continued to work every day. Petitioner returned to Dr. Vender on November 17, 2011. PX4 at 10, 30-31. He noted that she was being followed for possible abnormal flexor tendon interconnections with continued radial symptoms bilaterally. *Id.* Dr. Vender diagnosed Petitioner with tenosynovitis and he administered a steroid injection into the left wrist. *Id.*

Petitioner testified that she then began to make complaints about pain in her bilateral elbows. She explained that the pain would begin in her right wrist and go up to her elbow. Dr. Vender's medical records reflect that Petitioner returned on December 1, 2011 reporting no response to the left wrist steroid injection and continued complaints with left-sided radial pain and right-sided radial and ulnar pain. PX4 at 9, 29. Her most significant complaint was also medial elbow pain on the left. *Id.* Dr. Vender diagnosed bilateral tenosynovitis and medial epicondylitis. *Id.* He administered an injection into the left elbow. *Id.*

On January 12, 2012, Petitioner reported that her left elbow injection did help, but she still had pain with twisting motions as well as medial elbow pain. PX4 at 7-8, 18, 28. Secondarily, Petitioner also reported ulnar right wrist pain and various other complaints in both upper extremities. *Id.* Dr. Vender referred Petitioner to occupational therapy, gave her an elbow sleeve and kept her released to full duty work. *Id.*

On February 20, 2012, Dr. Vender noted Petitioner's most prominent complaint to be left arm pain. PX4 at 5-6, 26. He maintained Petitioner's diagnoses of bilateral tenosynovitis and left medial epicondylitis. *Id.* Dr. Vender indicated that no aggressive treatment was recommended for the multiple upper extremities complaints and he ordered a home exercise program. *Id.* Petitioner saw the occupational therapist on the same date and was instructed in home exercises for the bilateral wrists and left elbow. PX4 at 25.

Motor Vehicle Accident

On March 13, 2012 Petitioner arrived at the emergency room at Northwest Community Hospital. PX3. She reported that she was in a motor vehicle accident with no airbag deployment hit on the driver side coming out of the parking lot by another oncoming vehicle. *Id.* She complained of mild headache, neck pain, and bilateral lower rib cage pain. *Id.* She was diagnosed with a head contusion and neck sprain. *Id.* Petitioner was discharged home the same day with instructions to follow up with her primary care physician. *Id.*

Continued Medical Treatment

Then, on May 3, 2012, Petitioner returned to Dr. Vender once more. PX4 at 4, 24. Petitioner reported that she was feeling the same as at her last visit with worsening pain located in the left elbow that had been occurring for five months and bilateral wrist pain that had been occurring one year ago. *Id.* Dr. Vender noted that Petitioner's complaints were mostly related to the right upper extremity, which were diffuse in nature, and that her pain radiated toward her shoulder and neck. *Id.* She also reported diffuse pain on the left stopping at the elbow. *Id.* Dr. Vender noted that Petitioner's daughter was present and translated for her. *Id.* He also noted that "[he] discussed the complaints today with the patient and her daughter. There has been difficulty with the location and consistency of complaints and findings. Would recommend followup. With her primary physician or possibly a rheumatologist." *Id.* Petitioner testified that this was her last visit with Dr. Vender. For approximately one year, Petitioner did not see any physician for treatment of her elbows or wrists.

On April 9, 2013, Petitioner testified that she went to see John O'Keefe, M.D. (Dr. O'Keefe) at Central Medical Specialists who she found in a newspaper. Dr. O'Keefe's records reflect Petitioner's report on that date of bilateral wrist and hand pain as well as handwritten notes with the following history:

> Patient here seeking 2nd opinion for bil hand & wrist pain from overuse injury at work. Pt packs envelopes & constantly rolling envelopes. Saw several doctors & was diagnosed with tendonitis. Was given cortisone injections on both hands by Dr Vender.

PX5 at 3. Petitioner testified that she then spent several months without any medical treatment for her hands, wrists or elbows, but she continued to work for Respondent.

October 3, 2013

Petitioner testified that on October 3, 2013 she was working for Respondent when she sustained an injury. She explained that she was working on machine "RA5," which is an envelope machine that packs envelopes. A conveyor belt is located at approximately knee level. Petitioner explained that her arm was hurting her a little bit at the time. She explained that she filled up a box that weighed 65-70 pounds and was placing it onto a skid stacked seven boxes high. Petitioner testified that she lifted up the box, but she felt pain in her hand and her hand was not stable after which the box came toward her and made her fall down.

Petitioner testified that her right hand started to hurt although she grabbed the box as it was coming down with both hands, but let the box go because her right hand did not "respond." Petitioner testified that the box fell and she fell onto her buttocks such that her hands and buttocks hit the floor. She explained that she felt a strong pain in her right hand, a lot of heat in her whole body, and dizzy for a few seconds.

Petitioner testified that her boss, Mitch, came to pick her up, but she did not let him because she was very dizzy and in a lot of pain. She described that the pain in her right hand was different than her pain before in that it was much stronger.

On cross examination, Petitioner testified that she had both hands on the outside corners of the box and she was using her right hand to propel the box upward onto the skid overhead. Petitioner testified that when she lifted the box overhead it was heavy and she felt pain in her right hand and she let the box go, which is when it fell. Petitioner also testified that she felt pain all the way from her right hand into her neck. The box did not stay where it was supposed to and she felt pain in her right hand. Petitioner stated that she had pain in both wrists, but it was stronger on the right side. She also had a little pain in her elbows and fingers, but no pain in her shoulders. She explained that she could not remember if the pain was different than the pain that she felt in 2011.

Medical Treatment

Petitioner testified that she was sent to U.S. Health Works, which is the same clinic as Advanced Occupational Medicine, but with a new name. The medical records reflect that Petitioner saw Alan Sisson, M.D. (Dr. Sisson), who recommended ice and heat and prescribed wrist splints while working. PX5 at 15; PX6 at 9-16. Petitioner was also instructed on home exercises, given Ibuprofen and released back to full duty work. *Id.*

Dr. Sisson also provided a letter dated October 3, 2013 addressed to Ms. Mueller summarizing Petitioner's care at his clinic in 2011. PX6 at 9-11. Dr. Sisson noted the following reported history in pertinent part:

> I had the opportunity to see Ms. Sanchez in our offices on the evening of October 3, 2013. She states that at approximately 5:25 PM, on October 3, 2013, she was lifting a box up onto an overhead area when she experienced pain in her right wrist that resulted in her losing control of the box, which then began to fall and she attempted to arrest that fall using her hands. She now complains of pain in both wrists that radiates up her arms toward her shoulders. She had a previous history of bilateral wrist injuries in 2011, that I was detail momentarily. Her statement at the time of this visit was that her previous wrist pain "never got better" since the time of the initial injury in approximately January of 2011. At this time, she is experiencing both pain and numbness in her hands bilaterally. She states that this discomfort in her wrists and numbness in her hands occurs frequently.

Id. Dr. Sisson noted that Petitioner previously presented on May 5, 2011 reporting bilateral wrist pain since January of 2011, which was diagnosed as a bilateral wrist sprain. *Id.* Petitioner underwent conservative treatment and diagnostic testing. *Id.* Her June 2, 2011 bilateral wrist MRIs showed a "high-grade partial tear of the scapholunate ligament[, and the] results for the left wrist showed a scapholunate ligament sprain that was suspicious for a partial-thickness tear." *Id.* Petitioner was referred to Dr. Ostric, who noted that Petitioner might be suffering from carpal tunnel syndrome, but her EMG showed no evidence of radiculopathy or neuropathy. *Id.* Dr. Ostric administered a steroid injection into the right wrist and Petitioner was released from care on July 12, 2011. *Id.*

Dr. Sisson also noted that "[o]n July 29, 2011, [Petitioner] returned with complaints of having injured her wrist and neck while lifting a sack of garbage. At that time, conservative treatment was instituted and she was again discharged from our care." *Id.* After an examination on October 3, 2013, Dr. Sisson diagnosed Petitioner with a bilateral wrist strain and released her back to work full duty. *Id.* Dr. Sisson also indicated in pertinent part:

> This particular complaint of injury aside, it appears that she continues to complain of chronic bilateral wrist pain which has been exhaustively investigated without a treatable underlying etiology discerned. I will evaluate her one additional time for this particular injury; however, I do not believe that, ongoing beyond that visit, we will have anything of substance to offer her in terms of further evaluation and/or treatment. For that reason, I suspect that I will discharge her from care for this particular incident at the time of her followup visit. ....

Id.

Petitioner testified that the following day, October 4, 2013, she could not get out of bed. Petitioner testified that she did not go to work from October 4, 2013 to October 8, 2013.

Petitioner testified that she then saw John O'Keefe, M.D. (Dr. O'Keefe) on October 8, 2013. The Central Medical Specialists[2] records reflect Petitioner's report on that date of bilateral wrist and low back pain as well as handwritten notes with the following history:

> went to move 60# box of paper that was above her head for the machine to make envelopes, felt her (R) hand give and the box fell off, patient fell into a seated position hitting buttox + using both hands to break her fall.

PX5 at 2. In a typed progress note of the same date, Dr. O'Keefe's physician's assistant, Lauren Kirsch, PA-C, noted the following history:

> Patient works as an envelope machine operator for Federal Envelopes. She is a 9-year veteran with this company and works 40+ hours weeks. Her job requires her to lift and place 50-60 lb. boxes about 15x an hour to fill the machine with paper. She was injured on 10/03/13 when she was moving a 60 lb. box that was stacked higher than her head to load it into the machine. She felt her right wrist give way as she was trying to move the box, causing her to lose balance. The box fell onto the cement floor to her left and she fell backwards onto her buttocks into a seated position. She used her two hands to break her fall on either side of her. Her supervisor, Mitch, helped her up. She verbally reported the incident to him and Kelly from HR immediately after. She was then seen by the company doctor. They took x-rays of the bilateral wrist which were read as negative for fracture. She was given 2 wrist braces for her wrists and

[2] The records of Dr. O'Keefe were procured from "Central Medical Specialists" as well as an entity known as "Marian Orthopedics & Rehabilitation." See PX5 & PX6.

> ibuprofen 200mg. She was then told to go back to work. At present, she has increased pain in her low back and bilateral wrist from the fall. She is unable to sleep due to pain. Patient has a history of gastritis. She also has a history of bilateral wrist tendinitis in 2011 that was treated by Dr. Vendor. She states her wrist pain was virtually resolved until the injury at work 10/03/13 re-aggravated those problems. She has no prior history of back pain or pathology.

PX5 at 161-162, 318-321; PX7 at 61-63. Ms. Kirsch diagnosed Petitioner with a low back sprain and bilateral wrist sprains post work injury on October 3, 2013. *Id.* She recommended physical therapy, which Petitioner then began at the Central Medical Specialists clinic. *Id.*

A handwritten phone call note that appears to be taken by one of Dr. O'Keefe's staff indicates that Kelly from Respondent's Human Resources department called. PX5 at 32. Among other notations, the handwritten note reflects Kelly's message that if Petitioner had restrictions they could be accommodated, that Petitioner was expected to return to work the following day at 3:00 p.m. as she had been released with no restrictions by the company clinic, and noting that the "Company is suspicious that she is truly injured and that her fall 'looked faked.' She says pt has a history of magnifying her sx + not being compliant with her wrist splints[.]" PX5 at 32.

On October 17, 2013, Petitioner returned to see Dr. O'Keefe. PX5 at 158-160, 194-195; PX7 at 58-60; PX28 (Dep. Ex. 3)[3]. Dr. O'Keefe noted the following history and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Patient is a 9-year veteran at Federal Envelope. She had a severe injury 10/03/13. Her supervisor Mitch witnessed it. He actually helped her up from the floor. Her job as a machine operator and envelope manufacturer requires that she work at a very rapid pace. 15x an hour she lifts 50-60 lb. loads. They stack boxes well above the height of her head with that load. On 10/03/13, she was up on her toes trying to shove a box mostly with her right shoulder up above her head (it was the 7th row). Her arm popped with pain. The box fell towards her chest, knocking her to the ground. She fell backwards onto the concrete with her arms hyperextended. She had intense pain in her back, right shoulder, and both hands at that point. The company doctor did see the patient that day and sent her back to work. She's had numbness and tingling in the hands since that time and weakness in the shoulder. She has left> right sciatica which is new since this injury. Unbelieveably, HR is calling us and telling us that they think she's malingering. From my perspective, she's concise, accurate, consistent, and honest. HR is saying they have light duty.
> ....

Id. He ordered an H-wave machine and recommended continued physical therapy. *Id.* Dr. O'Keefe also indicated that "**[i]t's my board-certified orthopedic opinion that the patient was intact and working as a heavy laborer for 9 years prior to this episode. She's never had back pain or sciatica. She's never had severe shoulder sprain.** The peripheral neuritic symptoms that she has at present are severe but hopefully will resolve with therapy and splints." *Id.* (**emphasis** in original).

On cross examination, Petitioner testified that she did not receive bills for the H-wave machine and she is not sure whether it was paid for through insurance. On the same day, Dr. O'Keefe's records reflect a call from Kelly in Respondent's Human Resources department that they had light duty work for Petitioner. PX5 at 135. The noted response was that Dr. O'Keefe did not release Petitioner to work because of her physical examination and clinical findings. *Id.*

[3] The physical examination findings, review of diagnostics, etc. presumably located on page two of the three page progress note was not submitted into evidence in any of the exhibits.

On October 30, 2013, Petitioner returned to Dr. O'Keefe. PX5 at 133, 156-157, 193-194; PX7 at 56-57. Dr. O'Keefe noted the following history and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Patient is a 9-year veteran at Federal Envelope and had a heavy, unprotected fall. She was knocked off of her feet by a 50-60 lb. box that struck her chest as she was trying to place it above the height of her head. She contused and sprained both arms in her spine. She's been off work despite HR's strong orders to return to work. **It's my board-certified orthopedic opinion that this woman was seriously hurt and has a discal injury in the L/S spine producing intense neuritis in the right > left leg at present. She has strong neuritic symptoms in both arms from the strain and contusion that she sustained from that injury 10/03/13.** She was intact and without debility or problems for the year prior as she worked with these heavy loads on a near constant basis.

Id. (**emphasis** in original). Dr. McAfee diagnosed Petitioner with a heavy, unprotected full spraining her spine on October 3, 2013, modest resolution of cervical spinal problems, persistent lumbar contusion and sprain with right greater than left sciatica at present as well as a sprain and strain of both hands with neuritic symptoms in both arms. *Id.* He ordered a lumbar MRI and therapy. *Id.* Dr. O'Keefe kept Petitioner off work. *Id.* Petitioner had an initial occupational therapy evaluation at Dr. O'Keefe's office on November 5, 2013. PX5 at 130-132.

In a letter dated November 14, 2013, Shalonda Lockett (Ms. Lockett), Sr. Claims Adjuster of Employers Preferred Insurance Company, requested that Petitioner complete and return a questionnaire and medical authorization form. PX5 at 98-103.

On November 26, 2013, Dr. O'Keefe PX5 at 134, 153-155, 193, 197; PX7 at 53-55. Dr. O'Keefe noted the following history in pertinent part:

> Patient had a work injury witnessed by her supervisor 10/03/13. She hurt her spine and has traumatic bilateral carpal tunnel symptoms, worse on the right than the left. She still having strong dysesthesias into the right arm from the neck and into the right leg from the lumbar plexus. ....
>
> The patient is an 8-year veteran at this jobsite and has had no history of spine problems or radicular symptoms until this severe, unprotected fall with a 60 lb. load smashing her into the concrete from a standing position. History for the carpal tunnel is positive for some treatment by Dr. Vender in the past but she's had years of function without the ability. This isn't a pre-existing condition. ....

Id. Dr. O'Keefe ordered a cervical MRI after a "heavy unprotected fall @ work 10/3/13" and continued occupational therapy. *Id.* He also noted that "[i]t's my board-certified orthopedic opinion that the patients had a trauma 10/13 produced spinal injury with disco injury in the cervical and lumbar area, producing peripheral neuritic symptoms of traumatic carpal tunnel and right > left sciatica." *Id.*

Petitioner returned to the occupational therapist at Dr. O'Keefe's office on December 3, 2013. PX5 at 128-129. The therapist noted that Petitioner had been diagnosed with a right wrist sprain with a "gradual onset[.]" *Id.* She recommended six weeks of therapy twice per week. *Id.*

Dr. O'Keefe ordered another EMG/NCV, which Petitioner underwent on December 4, 2013. PX5 at 125-127. The EMG/NCV showed no evidence of cervical radiculopathy or peripheral entrapment neuropathy. *Id.*

On December 23, 2013, Petitioner underwent an MRI of the cervical and lumbar spine. PX5 at 121-124; PX8 at 15-18. The interpreting radiologist noted degenerative disc disease at L4-5 with a moderate size disc protrusion and bony spondylitic changes with associated stenosis, mild-to-moderate L3-4 stenosis with left-sided asymmetric disc protrusion and narrowing left of the midline and mild levoscoliosis. *Id.* In the cervical spine, the radiologist noted mild disc bulging diffusely at C3-4 and C5-6 with mild vertebral endplate bony spondylotic changes. *Id.*

On December 31, 2013, Dr. O'Keefe referred Petitioner to his colleague at Central Medical Specialists, Krishna Chunduri, M.D. (Dr. Chunduri), to assess and treat her neck and low back injury at work in October of 2013. PX5 at 28, 148-151, 191-192; PX7 at 48-51. Dr. O'Keefe noted the following history from Petitioner and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Patient was hurt with a well-documented injury 10/13. She weighs 140 lbs. and throws 60 lb. loads above the height of her head 15x an hour. She's Been 9 years of that job site. She's not had spine problems prior. She had some wrist symptoms in 2011 but no interval wrist symptoms until she was hurt 10/13. **It's my board-certified orthopedic opinion that she may have had some wrist injury back in 2011 but it was the 10/13 injury that is causing her present debility and symptoms.** Certainly the mechanism of throwing a 60 lb. box above the height of her head causing electrical pain into the neck and right arm and a painful pop in the wrist is a suitable mechanism to produce a triangular fibrocartilage complex (TFCC) tear and a discal injury. The patient has abnormal MRI of the C-spine 12/13 showing discal traumatic bulge at C3-4 and C5-6 and abnormal MRI from Molecular Imaging 12/23/13 of the lumbar spine showing L4 and L5 bulging disc injuries. Electrical testing 12/04/13 is negative for radiculopathy in the neck and both arms.
>
> On questioning, it's her neck and right arm pain that are most disabling. She's been working with OT with a vast improvement from initial assessment 10/13 but she still having a high level of symptoms. She's only tolerating 2 lbs. resistance. I talked to OT today as I examined the patient and with us both here she's having mechanical popping with ulnar deviation and loading the risk.

Id. (**emphasis** in original). Dr. O'Keefe diagnosed Petitioner with a throwing injury above the height of her head with 60 lb. loads producing discal injuries in the neck and low back, right radiculitis secondary to the first diagnosis, and right wrist TFCC symptoms persisting. *Id.* He ordered occupational therapy twice a week. *Id.* Dr. O'Keefe also noted that he spoke with Kelly and that Petitioner's IME should assess her neck, low back, and bilateral hands. *Id.*

Petitioner also saw an occupational therapist at Dr. O'Keefe's office on January 9, 2014. PX5 at 119-120. The therapist noted that Petitioner had been diagnosed with a right wrist sprain with a "gradual onset[.]" *Id.* She recommended two weeks of therapy twice per week. *Id.*

Petitioner first saw Dr. Chunduri on January 22, 2014. PX5 at 170-171, 190. The medical records reflect that Dr. Chunduri is a board-certified anesthesiologist and pain management specialist. *Id.* Dr. Chunduri noted the following history from Petitioner and gave the following opinions regarding the relatedness of her condition to an incident at work in October of 2013:

> Ms. Sanchez presents to the clinic with complaints of pain in her neck and mid-back, and lower back since her work injury 10/03/2013. She states she is a machine operator. She was placing a 50 lb. Box above her head when she suddenly felt pain in her neck and her arm. She was unable to securely placed the box which then fell down, causing her to fall onto her buttocks. She states that since his injury, she has been having throbbing, sharp, burning pain in her neck and her lower back. The neck pain she states

> radiates into her right upper extremity which feels numbness and tingling down her arm to her hand. She states that her low back pain radiates into her right buttock where she feels electric-like feeling in her upper thigh. She rates the pain as severe at 7/10. It is constant. It is worse in the mid-day and afternoon. It is worse with prolonged sitting, walking, lying down, and coughing. She states that standing makes it better. It affects her daily routine. She has been taking Meloxicam, Tramadol, and Prilosec and she has been in physical therapy.

Id. Dr. Chunduri diagnosed Petitioner with cervical spondylosis and cervicalgia as well as lumbar spondylosis and lumbago. *Id.* He prescribed a Medrol Dosepak, continued NSAIDs and continued physical therapy. *Id.* Dr. Chunduri also noted "[i]t is my opinion, based on a reasonable degree of medical certainty, that the above symptoms and diagnoses are causally related to the work injury and that the current treatments and recommendations are medically necessary." *Id.*

Petitioner returned to Dr. O'Keefe on January 28, 2014 solely for evaluation of the wrists noting that Dr. Chunduri was treating Petitioner for the low back. PX5 at 147, 189; PX7 at 47. He diagnosed Petitioner with resolving wrist sprains with poor ability to improve power. *Id.* He reduced physical therapy to once per week.

On February 6, 2014, Dr. Chunduri administered a right L4-L5 transforaminal epidural steroid injection. PX5 at 167-169. Petitioner testified that she remained off work as ordered by Dr. O'Keefe and Dr. Chunduri. On March 13, 2014, Dr. O'Keefe ordered continued physical therapy and requested authorization for epidural steroid injection into the lumbar spine and cervical spine. PX5 at 207; PX7 at 45-46.

On April 15, 2014, Dr. O'Keefe noted that Petitioner was 15 minutes late to her IME on January 6, 2014. PX5 at 139, 187, 206. She reported that her low back pain persisted, but was not as severe and that she continued to experience sciatica symptoms into the right leg. *Id.* She also reported continued bilateral wrist pain with less numbness in tingling into the digits. *Id.* Dr. O'Keefe ordered a series of 4-5 cervical epidural injections. PX5 at 137.

On May 15, 2014, Petitioner reported shooting pain from the right wrist to the elbow and mild low back pain. PX5 at 139, 142-143, 187, 206; PX7 at 42-44. Dr. O'Keefe noted that Petitioner "had a backward full heavily at work 10/13. She's been miserable with spine pain since." *Id.* He diagnosed an injury to the cervical and lumbar areas as a result of her heavy, unprotected fall at work in October of 2013 with abnormal MRIs from December of 2013 showing discal injuries. *Id.* Dr. O'Keefe also diagnosed Petitioner with bilateral carpal tunnel symptoms, right worse than left. *Id.* He indicated that Petitioner was miserable with neuritic symptoms, more in the neck then the low back and he recommended a trial of cervical epidural injections. *Id.* Dr. O'Keefe also indicated that he suspected that Petitioner's back would not be cured and she may need more of those injections in the future. *Id.* With regard to the carpal tunnel, Dr. O'Keefe indicated that it was partly being aggravated by Petitioner's cervical radiculitis and noted that he would hold off on advising surgery, but that she may need surgical release in the future. *Id.* He ordered continued use of the H-wave machine and physical therapy. *Id.*

Section 12 Examination – Dr. Weber

On May 19, 2014, Petitioner saw Dr. Kathleen Weber (Dr. Weber) at Respondent's request. RX1 (Dep. Ex. 2); PX5 at 92-97. Prior to this date, Petitioner testified that she had some appointments set with Dr. Weber, but she did not attend or she forgot to attend. On cross examination, Petitioner testified that she did not attend the prior

IMEs because on one occasion she spoke with her attorney at the time, and on another occasion it was 40 degrees below 0 and she got there 10 minutes late and Dr. Weber would not see her.

Dr. Weber's report indicates that she reviewed an incident report dated October 3, 2013 noting that "[t]he IE was raising a carton on top of a skid of boxes. The box was too heavy. The IE fell to the ground and injured both wrists and her lower spine." *Id.* Dr. Weber also reviewed the medical records of Dr. O'Keefe, Dr. Sisson, various utilization reviews and peer reports as well as Petitioner's May 7, 2014 lumbar MRI report. *Id.*

Petitioner reported to Dr. Weber through a translator that she had been a machine operator for nine years for Respondent and she had a prior bilateral hand repetitive trauma injury in 2011, but no prior low back injuries. *Id.* Dr. Weber noted the following history of accident:

> She states that on October 3, 2013, she was lifting a 50-pound box overhead, approximately 6-8 inches above her head. She felt right arm pain from her hand to her shoulder. The box began to fall and she tried to lift it back up but got dizzy and colleagues tried to help. Then, she states that she fell onto her buttocks. She is unsure if she had immediate back pain secondary to her dizziness. She caught herself with her hands. She was unable to stand and she was sent to the clinic. She states that following being evaluated at the clinic she went home. The next day she could not get out of bed, secondary to her whole back hurting. She did not return to the company clinic. She sought medical treatment with Dr. O'Keefe a couple of days later.

Id. Ultimately, Dr. Weber diagnosed Petitioner with bilateral wrist sprains and lumbar back sprain. *Id.* In so concluding, Dr. Weber noted that Petitioner's reported mechanism of injury changed within the medical records. *Id.* She opined that Petitioner's physical examination produced no objective findings or abnormalities, and determined that Petitioner's subjective complaints did not correlate with objective clinical findings on examination. *Id.* Dr. Weber stated Petitioner required no further care based on her normal exam, that she had reached maximum medical improvement, and had likely reached MMI within 4-6 weeks of the accident. *Id.* She stated Petitioner could return to work in a full duty capacity based on the normal exam. *Id.*

Utilization Reviews, Termination of Benefits & Continued Medical Treatment

The record reflects that Respondent obtained various utilization reviews dated May 6-8, 2014, July 10, 2014 and July 16, 2014. RX2-RX4; PX5 at 71-74; PX5 at 39, 44-46, 73. The reviews certified only 10 physical therapy sessions to the lumbar spine as of October 15, 2013 and 15 sessions to the bilateral wrists as of November 5, 2013. *Id.* The utilization reviews did not certify a series of cervical epidural injections recommended by Dr. O'Keefe, a prescription for Relafen, Tramadol, Dendracin, Prilosec, Mobic, Meloxicam, Omeprazole and Gabapentin. *Id.*

In a letter dated May 30, 2014, Shalonda Lockett (Ms. Lockett), Sr. Claims Adjuster of Employers Preferred Insurance Company, informed Petitioner's then-attorney that Petitioner's claim was being denied based on the independent medical evaluation report of Dr. Weber as well as the utilization reviews. PX5 at 91.

On July 8, 2014, Dr. O'Keefe noted the following: "[Petitioner] had a well-reported and documented injury 10/13. On that date, her normal duty was handling 50–60 lb. boxes, often above the height of her head. On such an occasion, the box slipped. She fell backwards heavily on both arms and landed on her rump on the ground behind her with this 60 lb. load falling. She had immediate pain in her spine and both arms." PX5 at 140-141, 185-186; PX7 at 40-41. Dr. O'Keefe diagnosed Petitioner with a lumbar discal injury with abnormal MRI as a

result of her injury at work in October of 2013. *Id.* He also indicated that Petitioner sprained and contused both arms. *Id.*

Petitioner underwent the updated EMG/NCV of the bilateral hands as well as of the low back on the following day, July 9, 2014. PX5 at 35-38; PX7 at 81-84; PX8 at 19-22. The results showed mild irritability present on EMG needle insertion at various muscles including those suggestive of L4-5 nerve root irritation. *Id.*

On August 7, 2014, Dr. O'Keefe noted that Petitioner was complaining of upper and lower spine pain, as well as bilateral arm pain, the month after her injury at work in October of 2013. PX6 at 37-38; PX5 at 136, 185. Among various other notations and opinions, Dr. O'Keefe indicated that "[w]e've been buried by work comp. with a worthless chart review done 07/16/14 that completely neglects the abnormal electrical test and MRI." *Id.* Dr. O'Keefe ordered a series of four transforaminal steroid injections. *Id.*

As referred by Dr. O'Keefe, Petitioner first saw Ossama Abedellatif Hassan, M.D. (Dr. Hassan) on September 25, 2014. PX8 at 88-90, 94. Dr. Hassan noted the following history of accident in pertinent part:

> Rosa Sanchez is a patient that comes to us with lumbar spine pain and cervical spine pain due to a work related accident suffered on 10/3/13. Patient states while working as a machine operator for Federal Envelope Company as she was lifting boxes repetitively above head level on one occasion one box weighing approximately 50 pounds fell back on patient forcing her to take weight and fall to floor hitting buttocks and bilateral hands she report it (sic) injury as she noticed supervisor witnessed accident she went to company clinic attempted light duty work but was unable to do continue as pain had increased she has been off work since then she has undergone one previous injection in 2013 with positive response she continues to exhibit pain today nothing has been able to stabilize pain since date of injury ....

Id. Petitioner reported cervical pain that radiated into both upper extremities and low back pain radiating into both lower extremities. *Id.* Dr. Hassan primarily diagnosed Petitioner with lumbar radiculopathy lumbar facet syndrome as well as cervical radiculopathy with cervical facet syndrome and he made a tertiary diagnosis of myofascial pain. *Id.* He ordered a lumbar MRI, lower extremity EMG/NCV, lumbar epidural steroid injection, lumbar foraminal steroid injection, cervical MRI, upper extremity EMG/NCV, trigger point injection for myofascial pain and a work conditioning program followed by a functional capacity evaluation. *Id.* Dr. Hassan also imposed light duty restrictions including no sitting or standing more than two hours at a time. *Id.*

Petitioner testified that she attempted to return to work with these restrictions, but she went to work and she was told that they did not have a position for her. She explained that she saw Kelly Mueller in Human Resources and that she told Ms. Mueller that her doctor recommended that she return to work with restrictions including no standing or walking over two hours and no lifting over 20 pounds. Petitioner testified that Ms. Mueller told her that they did not have a position for her with those restrictions.

On September 11, 2014, Petitioner saw Dr. O'Keefe who noted the following history in pertinent part:

> Patient was heard with a well-reported and documented injury while working 10/13. A 50-60 lb. load cell from above the height of her head, forcing her hands into hyperextension. The load then made her fall backwards onto her rump, injuring her spine in the neck and low back. The hands took another blow at that point she tried to break the fall as she was falling back with her hands. We've been treating her for severe wrist sprains, worse on the right than the left, since she was first seen 5 days after the injury. She had a single injection 02/14 which was beneficial. That practitioner left our practice and we've not had authorization to proceed with further injections. My board-certified orthopedic opinion is that she

> has serious problems with her neck with discal injury evidence on MRI from 12/13 at the cervical C5-6 levels and in the lumbar L4-5 levels. She has abnormal electrical testing per Dr. Paly, M.D. 07/14 showing a right L4-5 radiculopathy. At this point I'm referring her to Dr. Hassan, pain management Dr., for assessment and treatment. ....

PX6 at 34-35. Dr. O'Keefe also noted that he received an IME from Dr. Weber dated May 19, 2014. *Id.* he indicated that the report only assessed Petitioner's low back and hands, although the patient asked Dr. Weber to assess the neck which she refused. *Id.* Dr. O'Keefe indicated that he disagreed with Dr. Weber's report noting that the exam took 20 minutes and the patient was not in a gown. *Id.* He also noted Dr. Weber's indication that Petitioner had no symptoms with TFCC provocative testing although Petitioner reported to him that she did tell Dr. Weber that it was painful when her wrist was put through range of motion. *Id.*

Dr. Hassan administered a trigger point injection, an epidural steroid injection and a sacral medial branch block in the low back on October 8, 2014. PX8 at 82-87. Petitioner returned to see Dr. Hassan on October 14, 2014 at which time he recommended bilateral radio-frequency ablation. PX8 at 77-81.

Petitioner underwent the recommended lumbar MRI on October 17, 2014. PX8 at 14. The interpreting radiologist noted disc herniations at L3-L4 and L4-L5 as well as mild spinal stenosis and bilateral neuroforaminal narrowing on the left at L4-L5. *Id.* Petitioner also underwent the recommended cervical MRI, which the interpreting radiologist noted showed a 1-2 mm posterior annular disc bulge at C5-C6 without spinal stenosis or significant neuroforaminal narrowing. PX8 at 13.

Petitioner then underwent the recommended radio-frequency ablation as well as an epidural steroid injection and trigger point injection on October 24, 2014. PX8 at 72-76. On October 30, 2014, Petitioner returned to Dr. Hassan who recommended another radio-frequency ablation into the lumbar spine. PX8 at 67-71.

On November 11, 2014, Dr. O'Keefe diagnosed Petitioner with a work-related sprain of the right wrist producing a traumatic DeQuervain's contracture of the right "1st ray" and distal forearm for which he ordered an ultra-sound guided cortisone injection. PX6 at 31-32. He also diagnosed Petitioner with a cervical and lumbar spinal injury with disc herniation per Dr. Hassan. *Id.*

Petitioner underwent the recommended radio-frequency ablation as well as an epidural steroid injection and trigger point injection on November 22, 2014. PX8 at 62-66. Petitioner testified that Dr. Hassan kept her off of work. Dr. Hassan's records reflect Petitioner's report on November 25, 2014 and January 20, 2015 that her lumbar condition had improved. PX8 at 54-61. He recommended proceeding with cervical injections. *Id.*

In the interim, on December 16, 2014, Dr. O'Keefe noted his "board-certified orthopedic opinion that [Petitioner] does have discal neck symptoms." PX6 at 28-30. He diagnosed Petitioner with a "[w]ell-documented injury at work, hurting her neck and low back with discal herniation seen from abnormal MRIs 12/13." *Id.* Dr. O'Keefe ordered a repeat cervical MRI and repeat EMG/NCV. *Id.* Petitioner underwent the cervical and bilateral upper extremity EMG/NCV on January 7, 2015. PX6 at 85-87. The results showed no evidence of cervical radiculopathy or peripheral entrapment neuropathy. *Id.*

Dr. O'Keefe also referred Petitioner to Mark Sokolowski, M.D. (Dr. Sokolowski) for assessment and treatment. PX9 at 4. Petitioner first saw Dr. Sokolowski on December 22, 2014. PX9 at 7-8. Petitioner reported neck pain with radiation to the right upper extremity, lumbar pain with radiation to the right lower extremity, left

hand pain and symptoms subsequent to a work injury. *Id.* Dr. Sokolowski noted the following history in pertinent part:

> ... [Rosa Sanchez] reports that she was in her usual state of health, and working in the course of her usual occupation, on October 3, 2013. Her job requires that she place envelopes into 60-pound boxes. She then lifts the boxes onto a skid. She reports that she was performing these duties, and lifting the boxes onto a skid stacked high enough that it was necessary for her to lift the box above eye level. As she lifted one such box of envelopes onto the skid, she developed shooting pain from her wrist through her right arm to her neck as well as left-sided hand pain. As the box started to slip, she lost her balance and fell backwards landing on her buttocks, catching herself on the ground with both arms. She reports that her supervisor saw her fall and came to assist her. She reported that she was very dizzy and unable to stand. ....

Id. Dr. Sokolowski reviewed Petitioner's cervical MRI of December 17, 2014. *Id.* He noted no large disc herniations. *Id.* Dr. Sokolowski also reviewed Petitioner's lumbar MRI from October of 2014. *Id.* He noted a central and left-sided disc herniation at L4-5 and an annular tear at L3-4. *Id.* Dr. Sokolowski diagnosed Petitioner with cervical pain and radiculopathy as well as lumbar pain and radiculopathy. *Id.* He ordered a cervical EMG to determine the etiology of Petitioner's symptoms versus peripheral entrapment process. *Id.* He also indicated that Petitioner was a candidate for a lumbar laminectomy from L3-5. *Id.*

On January 15, 2015, Petitioner returned to Dr. O'Keefe who noted the following history:

> Patient had a fall to the floor while working 10/03/13. She had shooting pain in the upper extremity as she held a 60 lb. load. She lost control of back and dropped back box which was about the height of her head. That knocked her off of her feet and she fell backward onto her arms, injuring her spine and both hands, right worse than left. We've tried to improve her with McKenzie and core strengthening exercises. She still having a high level of symptoms. She's had some pain management injections in the mid and low back with Dr. Hassan, M.D. in 2014. She's due to see him on 01/20/15. Dr. Sokolowski, M.D. assessed the patient and feels she is a candidate for some lumbar fusion needs because of this work injury. I saw the patient 12/14 and ordered a repeat MRI of the neck. That's not normal but it's not horribly abnormal. She had a repeat electrical test which was negative for neck and arm neuropathy. **It's my board-certified orthopedic opinion that she has traumatic discal injury in the next and it is causing clinical symptoms into the right arm and traumatic carpal tunnel symptoms.** We asked work comp. Several months ago for permission to do an ultrasound-guided cortisone injection. That's not been forthcoming. Will bring her back in the next week or two and do that as she's worsening and is very debilitated.

PX6 at 25-27 (**emphasis** in original). Dr. O'Keefe noted that electrical testing performed on January 7, 2015 for the neck and arm was negative for neuropathy/radiculopathy. *Id.* Petitioner's cervical MRI as noted by Dr. O'Keefe showed a mild herniation of the C5-6 disc with some thecal effacement and no apparent stenosis. *Id.*

On January 27, 2015, Petitioner returned to Dr. O'Keefe who noted that Petitioner had clinical evidence of a TFCC tear and traumatic carpal tunnel syndrome on the right. PX6 at 23-24. He also diagnosed Petitioner with DeQuervain's, traumatic carpal tunnel syndrome and a TFCC tear in the right wrist. *Id.* Dr. O'Keefe ordered a cortisone injection trial for the carpal tunnel syndrome or the DeQuervain's. *Id.*

On January 28, 2015, Dr. Hassan administered the recommended cervical medial branch block as well as an epidural steroid injection and trigger point injection. PX8 at 47-53. Petitioner returned to Dr. Hassan on February 3, 2015 reporting increased lumbar spine pain. PX8 at 43-46. He recommended a discogram and CT

scan as well as trigger point injection for myofascial pain as needed. *Id.* Dr. Hassan performed the recommended discogram and post-discogram CT scan the following day. PX8 at 10-12, 34-42. On cross examination, Petitioner testified that she was under anesthesia during the discogram.

On February 10, 2015 and March 5, 2015, Dr. Hassan recommended additional injections into the cervical spine and referred Petitioner for a surgical consult related to the low back. PX8 at 32-33. In the interim, on February 12, 2015, Petitioner underwent the recommended EMG/NCV. PX8 at 8-9. The radiologist noted the following history:

> The patient is a 48 year old female of (sic) with chief complaints of pain in her neck and lower back with pain, numbness and tingling in her arms and legs. She reports that 10/03/2013 she was at work lifting boxes and on one occasion she lifted a heavy box over her head when it came down on her, she fell back onto her knees and lower back. She had the immediate onset of pain in her neck and lower back pain, numbness and tingling in her arms and legs. She notes that she has been receiving care, with improvement; however, pain in her neck and lower back, with pain, numbness in tingling in her arms and legs persists. She noticed difficulty in sitting, bending and twisting. Her past medical history is unremarkable. ....

Id.

On February 26, 2015, Petitioner returned to Dr. O'Keefe who diagnosed traumatic carpal tunnel syndrome on the right. PX6 at 21-22. He ordered an ultra-sound guided cortisone injection to address DeQuervain's as well as another injection to address carpal tunnel syndrome if those symptoms did not improve. *Id.*

On March 31, 2015, Dr. O'Keefe ordered a repeat low back MRI. PX6 at 16-18. He noted that "**[i]t's my board-certified orthopedic opinion that the fall of 10/13 produced DeQuervain's symptoms in both wrists and peripheral neuritic symptoms in both arms which should be treated.** At this point, work comp. should authorize the ultrasound-guided injection of the 1st and 2nd dorsal compartments on the right. **Work comp. should authorize Dr.** Sokolowski's **request to perform spinal surgery.** She's miserable and can't work with those symptoms." *Id.* (**emphasis** in original). Dr. O'Keefe also reiterated that he reviewed Petitioner's IME report, with which he did not agree, and that the exam was not thorough. *Id.* He wrote a "prescription asking for her to have a genuine and thorough exam of her arms." *Id.* Petitioner underwent the recommended low back MRI on March 31, 2015. PX6 at 88. The interpreting radiologist noted L3-4 and L4-5 disc herniations that impinged the ventral margin of the dural sac. *Id.*

On April 10, 2015, Petitioner returned to Dr. Sokolowski. PX9 at 6. Petitioner testified that she knows that he reviewed her MRIs because she observed him reviewing her films. Dr. Sokolowski maintained his diagnoses and recommendation for a cervical EMG and lumbar laminectomy from L3-5. *Id.*

On April 14, 2015, Petitioner returned to Dr. Hassan who indicated that she was awaiting approval for surgery as recommended by Dr. Sokolowski. PX8 at 4-5, 26-28. He also recommended a surgical consultation related to the cervical spine. *Id.*

Dr. O'Keefe then ordered a right hand MRI, which was performed on August 8, 2015. PX6 at 64-65. The interpreting radiologist noted that the MRI showed a small wrist joint effusion, mild osteoarthritis most prominent in the first CMC joint, and was otherwise normal. *Id.*

Thereafter, from June 15, 2015 through September 29, 2015, Dr. O'Keefe has continued to recommend surgery to the right hand as well as the surgery recommended by Dr. Sokolowski to the low back. PX6 at 6-13. Petitioner last saw Dr. Hassan on August 18, 2015. PX8 at 1-3. He diagnosed Petitioner with cervical radiculopathy and cervical facet syndrome, lumbar radiculopathy and lumbar facet syndrome as well as myofascial pain. *Id.* Dr. Hassan maintained that Petitioner required a surgical consultation for the cervical spine, follow up with Dr. Sokolowski for the lumbar spine, and trigger point injections for her myofascial pain as needed. *Id.*

Deposition Testimony – Dr. O'Keefe

On November 12, 2015, Petitioner called Dr. O'Keefe as a witness and he gave testimony at an evidence deposition regarding Petitioner's medical treatment and his opinions. PX28. Dr. O'Keefe is a board-certified orthopedic surgeon. PX28 at 4-6, 72; PX28 (Dep. Ex. 1).

Dr. O'Keefe testified that traumatic carpal tunnel syndrome could occur if Petitioner fell heavily onto her wrists and he opined that she could have further torn a pre-existing TFCC tear causing an aggravation of the condition as a result of this mechanism of injury. PX28 at 14. He explained that even if Petitioner had a prior MRI showing a TFCC tear, she reported to him that she was functioning at a high level "hoisting up 60-pound boxes over her head, throwing them up over her head on her tiptoes 15 times an hour. You couldn't do that with a torn wrist." *Id.*, at 62-63. Dr. O'Keefe also opined that the treatment that he rendered to Petitioner was "absolutely connected" with her injury at work noting that she had been working for eight months before the injury without any problems. *Id.*, at 61-62, 64.

Dr. O'Keefe opined that the medications provided by Dr. Chunduri were indicated. *Id.*, at 45. Dr. O'Keefe also opined that the lumbar surgery recommended by Dr. Sokolowski was reasonable and necessary because "[w]e've had a cooperative patient that has tried therapy and medicines and restricted activity and injections, and she's not nearly good enough." *Id.*, at 58. He further opined that the treatment rendered by Dr. Hassan was reasonable and necessary. *Id.*, at 58-59. As of the date of his deposition, Dr. O'Keefe wanted to perform an arthroscopic "assessment" surgery of the sprain of the ulnar aspect of Petitioner's right wrist. PX28 at 59.

Dr. O'Keefe also disagreed with the opinions of Dr. Weber noting that she "doesn't have a real clue on this patient." PX28 at 65-66.

On cross examination, Dr. O'Keefe testified he performs surgery on "toes, fingers, hands, ankles, hips, knees," and that the spine is "the one I don't do." PX28 at 72. He testified half his patients have workers' compensation claims and that Petitioner found him through the "Hoya" newspaper[4]. *Id.*, at 72-73.

Dr. O'Keefe testified that Petitioner presented for a second opinion in April of 2013 reporting repetitive activity and treatment by Dr. Vender. PX28 at 73. He explained that Petitioner's bilateral wrist complaints from April of 2013 and October of 2013 were not the same. *Id.*, at 73-74. Dr. O'Keefe explained that "[t]he glaring difference is that she didn't have an explicit trauma for the treatment she had in 5 of '11. She did work activities. And I think she was told by Dr. Vender it was just kind of a repetitive use situation. But let me get to the actual note. I'm going for 4 of '13. Here we go. Cortisone injections that were beneficial, so she's just kind of asking what's going on and not saying I need surgery or anything. She's just saying, what do you think what

[4] *Hoy* is a Spanish language newspaper based in Chicago. http://www.vivelohoy.com/ (last visited May 10, 2016).

my physical exam is?" *Id.*, at 74. He maintained that Petitioner's bilateral hand symptoms were "[h]ugely" different in October of 2013 from those in April of 2013. *Id.*, at 75-76.

On cross examination, Dr. O'Keefe refused to directly respond to questioning about whether Petitioner had reached maximum medical improvement or if her condition had resolved between her visit in April of 2013 and her return to him in October of 2013. PX28 at 76-77. He explained that Petitioner had a mild overuse condition in April of 2013 and that he was not aware that Petitioner had a prior injury in April of 2013. *Id.* Rather, he testified that he did not know of a prior injury and that Petitioner had "so much trauma in October that that would have completely overwhelmed this April 13 assessment. She had mild symptoms there with no restrictions needed and not even for sure she needed medicines. When I saw her the first time, she's badly hurt and needs narcotic medicines and can't work. So I can't - - she was supposed to come back if she was having significant symptoms, at which I would feel more comfortable with them saying an injury in April of '13. I don't think it was an injury in April of '13 that I saw her for." *Id.*, at 77. Dr. O'Keefe further explained that Petitioner did not return to see him after April of 2013, which she was supposed to do, so he thinks she did well based on the lack of a follow up appointment. *Id.*, at 78-79.

Also on cross examination, Dr. O'Keefe testified regarding his physician's assistant's notations of the mechanism of injury and Petitioner's condition on October 8, 2013. PX28 at 80-83. He understood that Petitioner "was on her toes trying to push the box to stack it on the seventh row of a pallet... [a]nd it got hung up or hooked up and came back at her, hitting her in the chest and knocking her back onto her hands and her butt." *Id.*, at 80. He testified that the height of the box involved was significant because "she's probably not in very perfect balance[,]" she "is extremely extending" and the box at that height is "probably very capable of knocking her back onto her feet." *Id.*, at 81. Dr. O'Keefe also testified that the weight of the box as reported by Respondent was significant because a 50-60 pound box, or even a 40 pound box, would have been a third of Petitioner's body weight and enough to knock her off her feet. *Id.*, 79-80. With regard to a potential inaccuracy in Petitioner's accident history, Dr. O'Keefe explained that "[s]ome women don't know the right amount of a weight." *Id.*, at 98. Regardless, Dr. O'Keefe acknowledged that his physician's assistant's note of October 8, 2013 does not reflect a report by Petitioner that she injured her right shoulder, hyperextended her arms, or of any complaint of neck or right shoulder pain. *Id.*, at 81-83.

Dr. O'Keefe maintained that Petitioner had traumatic carpal tunnel syndrome, ulnar tunnel symptoms and a TFCC tear. *Id.*, at 86-89. He maintained that these diagnoses would be clinically diagnosed and that diagnostic tests, which in Petitioner's case were all negative, was unnecessary to accurately diagnose the conditions. *Id.* He maintained that Petitioner's symptoms were also caused by a cervical disc issue despite the lack of evidence of cervical radiculopathy or peripheral entrapment neuropathy at the time of Petitioner's cervical EMG in January of 2015. *Id.*, at 92-93.

Dr. O'Keefe was clearly and repeatedly asked what specific surgery or surgeries he recommended for Petitioner and what conditions such treatment was intended to address. PX28 at 94-95. In an evasive and generalized manner, he testified that "[w]e're putting in to do an arthroscopy of the wrist[,]" and that he was looking for perform an arthroscopic "assessment" of the TFCC tear and possibly, in two other surgeries, repair Petitioner's carpal tunnel syndrome and DeQuervain's syndrome. *Id.* He added, "[w]e would not - - this lady has got a complex problem here. She has carpal tunnel findings. What I would do is say, hey, Rosa, what is your worst symptoms right now, which of these three things. And I would try to go for that. But any of these things could be surgical and probably will. We'll probably work on one of them, have an improvement there, and then go to the next most-troublesome thing." *Id.*, at 95-96.

Continued Medical Treatment

On November 17, 2015, Petitioner returned to Dr. O'Keefe. PX6 at 4-5. He reiterated that Petitioner was hurt at work in October of 2013 and that she had severe mechanical symptoms in her right wrist. *Id.* Specifically, Dr. O'Keefe noted that "[w]e've asked to perform an arthroscopic procedure as an outpatient with probable open repair of the triangular fibrocartilage complex (TFCC) ligament. She has carpal tunnel symptoms and cubital tunnel symptoms on the ipsilateral side, even in the face of normal electrical testing. If we do the wrist scope and deal with the mechanical symptoms but the neuritic symptoms persist, she may well require nerve releases." *Id.*

Deposition Testimony – Dr. Sokolowski

On December 7, 2015, Petitioner called Dr. Sokolowski as a witness and he gave testimony at an evidence deposition regarding Petitioner's medical treatment and his opinions. PX29. Dr. Sokolowski is a board-certified orthopedic surgeon specializing in the spine. PX29 at 4-5; PX29 (Dep. Ex. 1).

Dr. Sokolowski testified that Petitioner's cervical and lumbar spine conditions as of Petitioner's first visit with him were causally related to her injury at work on October 3, 2013 based on the correlation between the event and onset of symptoms, the lack of pre-existing pathology in those regions, his physical examination findings and corroborative diagnostic studies. PX29 at 11-12. He maintained his opinions as of Petitioner's second visit on April 10, 2015. *Id.*, at 15-16. Dr. Sokolowski specifically opined that Petitioner's lumbar radiculopathy, disc herniation at L4-L5 and annular tear at L3-L4 were more likely than not caused by the incident at work. *Id.*, at 16-17. With respect to the neck, Dr. Sokolowski ordered an EMG, if one had not already been performed, as well as a lumbar laminectomy surgery. *Id.*, at 15-16.

On cross examination, Dr. Sokolowski testified that he believed the mechanism of injury described by Petitioner caused her cervical and lumbar findings. PX29 at 20-21. Specifically, he understood that Petitioner was extending a box weighing 60 pounds overhead and that she fell on her buttocks. *Id.* Dr. Sokolowski trusted Petitioner with regard to the reported history. *Id.*, at 21.

Dr. Sokolowski also testified that disc pathology in the cervical spine was not causing Petitioner's right arm symptoms. PX29 at 23. He explained that "[w]e have excluded disc pathology because I did not observe a herniation. Based on her symptoms, she more likely has peripheral entrapment." *Id.* Dr. Sokolowski also testified that the etiology of Petitioner's cervical symptoms was unclear. *Id.*, at 30.

With regard to the lumbar spine, Dr. Sokolowski testified that Petitioner's central findings were a probative cause of her central symptoms. PX29 at 26. He acknowledged that it was not typical for a left-sided herniation to cause symptoms on the right side, but he explained that Petitioner had central and left-sided herniation so there was a reasonable expectation of bilateral nerve root involvement. *Id.*, at 27. Dr. Sokolowski acknowledged that Petitioner had pre-existing pathology (i.e., disc desiccation) at L3-L4 and L4-L5. PX29 at 28.

Continued Medical Treatment

On December 31, 2015, Dr. O'Keefe indicated that Petitioner had a severe right wrist sprain from her work injury in October of 2013 with an abnormal MRI showing a TFCC injury, which was tremendously alleviated for a few hours after an ultra-sound guided cortisone injection. PX6 at 3. Dr, O'Keefe noted that "**[t]his**

patient needs to have the outpatient arthroscopic procedure performed. There is little I can do to get her back to being functional as a worker who is supposed to handle 50-60 lb. loads when she has a torn ligament in her wrist that's causing painful weakness and arc of motion. Work comp. needs to authorize this immediately or else set her up with a new IME with a hand surgeon to assess this genuine and severely injured patient after the work injury of 10/13." *Id.* (**emphasis** in original). He kept Petitioner off work. *Id.*

Deposition Testimony – Dr. Weber

On January 13, 2016, Respondent called Dr. Weber as a witness and she gave testimony at an evidence deposition regarding Petitioner's conditions and the relatedness, if any, of her conditions to an injury at work. RX1. Dr. Weber is board-certified in internal medicine and sports medicine. RX1 at 5-8; RX1 (Dep. Ex. 1).

Dr. Weber explained Petitioner's back examination was within normal limits with the exception of subjective complaints with lumbar range of motion, and had no neurologic abnormalities. RX1 at 13. She did not diagnose lumbar radiculopathy because Petitioner exhibited no symptoms which suggested neural tension, such as a straight leg or cross leg raise, and a negative slump. *Id.*, at 15. Dr. Weber stated that although Petitioner reported some decreased sensation in the distal right thigh, the exam was normal. *Id.*, at 15-16. Dr. Weber also reviewed Petitioner's low back MRI report noting degenerative changes in the lumbar spine, which were not symptomatic at the time of her examination. *Id.*, at 13, 26.

Dr. Weber testified that she reviewed Petitioner's bilateral wrist MRI reports, which suggested chronic scapholunate abnormality and preexisting degenerative changes. RX1 at 13, 26. Dr. Weber explained she did not diagnose a TFCC tear because Petitioner had no tenderness over the TFCC and provocative testing of the TFCC did not reproduce any symptoms. RX1 at 14. Though Petitioner had MRI findings at the scapholunate, her physical exam yielded no scapholunate pain or instability. *Id.* Dr. Weber also testified that she did not diagnose carpal tunnel syndrome because Petitioner "had no findings that would suggest carpal tunnel in the sense that she had negative Tinel's and negative Phalen's bilaterally at the wrist[]" with no evidence of atrophy. *Id.* Dr. Weber further explained she did not diagnose Petitioner with DeQuervain's syndrome because Petitioner did not have an unequivocal Finkelstein's and because the mechanism of injury described by Petitioner would not have caused it. *Id.*, at 14-15.

Ultimately, Dr. Weber maintained that Petitioner's presentation was wholly subjective and did not correlate to any objective findings. RX1 at 15-16. "Based on the described mechanism of injury it appeared that she more probable than not sustained a mild wrist and lumbar back strain." *Id.*, at 16. Dr. Weber testified that "there is a suggestion of non-physiological causes for ongoing subjective complaints as her exam was normal." *Id.*, at 22. Dr. Weber testified that the accident as described by Petitioner did not aggravate any pre-existing scapholunate or degenerative lumbar spine findings. *Id.*, at 18.

Dr. Weber testified that a reasonable course of treatment for Petitioner's condition resulting from the October 3, 2013 accident would have been a short course of physical therapy and medications lasting 4-6 weeks. RX1 at 19-20. She explained that injections were not necessary because there was nothing in the record to suggest any true radicular-type symptoms. *Id.*, at 29. She also explained that epidural injections are not indicated for numbness, but rather for radicular type symptoms, and she noted that the Central Medical Specialists records showed nothing to suggest positive straight leg raises or slump tests. *Id.*, at 20. Dr. Weber testified that Petitioner had a normal exam and no further medical treatment was necessary. *Id.*, at 21.

On cross examination, Dr. Weber testified that if Petitioner fell backwards on her buttocks and hands she could aggravate a TFCC tear, increase a scapholunate tear and increase symptoms in the lumbar spine. RX1 at 26-27. Dr. Weber acknowledged that she did not evaluate Petitioner for a cervical spine condition. *Id.*, at 27.

Continued Medical Treatment

Petitioner testified that she has continued to see Dr. O'Keefe through March 31, 2016 and he has continued to keep her off of work. On March 31, 2016, Dr. O'Keefe continued to recommend surgery to repair a right wrist TFCC tear and requested authorization of the back surgery recommended by Dr. Sokolowski. PX7 at 1-2. He noted the following in pertinent part:

> ... [Petitioner] was hurt so badly in 10/13 that she wasn't able to go back without restrictions. We did try to have her go back but work wouldn't have her. She's been a very compliant patient on maximum doses of medications, including NSAIDs, Aciphex, Hydrocodone, and Neurontin. She had gastric symptoms and even had an endoscopy which that doctor said was probably related to the prescription medicines we've been providing. **Ideally we'd be allowed to do the surgery so that we wouldn't be trying to suppress these high symptoms with medications. Work comp. should authorize the requested surgeries ASAP (the back surgery with Dr.** Sokolowski, **M.D. was requested 04/15 and the right arm surgery was requested 08/15). It's my board-certified orthopedic opinion that the patient was hurt with work activities 10/13 and had a back injury and discal symptoms with right radiculitis which should be authorized for Dr.** Sokolowski **to performing back surgery on.** Her right arm remains problematic with numbness and tingling in the ulnar and median nerves. We asked for ultrasound-guided cortisone injection of the wrist back in 08/15. That occur from a 7/10 level to a 0/10 for a brief time. The triangular fibrocartilage complex (TFCC) ligament needs to be addressed with arthroscopic exam as requested 08/15.

Id. (**emphasis** in original). Petitioner testified that she wishes to undergo the surgery recommended by Dr. O'Keefe and the low back surgery as recommended by Dr. Sokolowski.

Prior to October 3, 2013, Petitioner testified that she did not have any low back problems. She also testified that she has not had any accidents thereafter. On October 13, 2012, Petitioner testified that she was involved in a motor vehicle accident and she underwent CT scans of her neck and her thorax and chest. She also had CT scans of her abdomen and hips. She was treated and released from the emergency room on that date, but did not have any further follow up care thereafter as a result of her accident.

Regarding her current condition, Petitioner testified that she does not engage in any activities at 100%. She explained that this is due to her right wrist pain and her low back pain. While walking, Petitioner testified that her whole right side becomes numb, her right knee does not allow her to descend stairs easily and her right big toe is always numb. Petitioner explained that she can walk for about 15 minutes before her pain starts.

While ascending or descending stairs, Petitioner testified that there is no time when she does not feel pain in her right knee. Petitioner described that she has to adjust her right knee when she ascends or descends stairs because she does not have strength. She also has low back pain and she cannot sit for long periods of time in one position or any position. Petitioner testified that, at the time of the hearing, she had been sitting for over an hour and 15 minutes and she felt a lot of pain in the right buttock and low back.

With regard to her right hand, Petitioner testified that her fingers become numb. She experiences pain and feels cracking with movements of the right wrist such as while using a knife, washing dishes, or stirring food while

cooking. Petitioner testified that she uses a wrist brace on both wrists at night and she uses a brace on her right wrist most of the time. Petitioner takes Tylenol and pain medication prescribed by Dr. Smith, her primary care physician, for her right wrist pain sometimes three times per day.

On cross examination, Petitioner testified that Dr. Smith told her that the medications are for her nerves, but she could not recall the names of the medications. She also testified that her right hand pain is now stronger than it was in 2011 and she has different symptoms in the left hand compared to the right hand. On the left, Petitioner testified that she feels wrist pain, but no numbness in the fingers. Petitioner testified that she has not had any subsequent accidents to her hands.

Mitchell Silva

Respondent called Mitchell Silva (Mr. Silva) as a witness. Mr. Silva testified that he is currently employed by Respondent as a Plant Manager and has worked there for 15 years. Mr. Silva oversees all three shifts, primarily overseeing machines.

Mr. Silva testified that Petitioner was a second shift Operator. He explained that Petitioner's main responsibility was to check quality and pack envelopes inside cartons measuring 21¼ x 12¼ x 9⅞ that weighed an average of 30 pounds when full. Mr. Silva testified that he knew the dimensions and weight of these boxes because he ordered 20,000 every month. Mr. Silva testified that Petitioner was to place filled boxes onto pallets and complete a production sheet with totals for the day. Pallets held 36 cartons and were stacked six cartons wide and six cartons high. Each full pallet measured about 54 inches tall including the height of the pallet, which is 4-5 inches. Mr. Silva testified that the cartons were not supposed to be stacked seven cartons high because the weight would crush the bottom cartons.

On October 2, 2013, Mr. Silva testified that he was working with Petitioner and he observed the alleged accident. He explained that he was walking toward her machine and noticed her pick up a box and walk toward a center aisle. She lifted the carton chest high on the skid, paused, then awkwardly and slowly went down to her left side and made a quick yelp. He testified that Petitioner landed on her left wrist and elbow. Mr. Silva testified that Petitioner was putting the box onto the fifth level of boxes on the skid at approximately chest height at the time of this incident and that he was only 10 feet from her when he witnessed the incident.

Mr. Silva testified that he asked Petitioner if she was ok and she grabbed her right wrist and elbow. Although he testified that he saw Petitioner land on her left wrist and elbow, Petitioner told him that she fell on her right wrist and elbow. Mr. Silva testified that he did not recall helping Petitioner up from the floor.

Mr. Silva then reported the accident to Kelly Mueller (Ms. Mueller) in the Human Resources department. Mr. Silva told Ms. Mueller that there was an incident where an employee said she was hurt. He testified that Petitioner landed on her butt and her left hand was down and when he went over to her she was holding her right hand. He did not observe her on her right hand and he did not observe Petitioner's right hand hit the ground.

Respondent offered into evidence a compilation of photographs taken by Mr. Silva of the pallet involved in the incident from different angles. RX7. Mr. Silva testified that these photographs were taken the day after the incident.

On cross examination, Mr. Silva testified that the photographs show the pallet stacked five cartons high and he explained that a pallet can be stacked up to six cartons high. He testified that each carton weighed about 30 pounds. He testified that, if someone is only 5'2 tall, that person would not have to lift a carton over shoulder level to get it onto the fifth level of cartons. Mr. Silva testified that he actually observed Petitioner putting the box up on the pallet. He explained that he was looking at Petitioner from her left side. He explained that Petitioner put the box on the pallet, hesitated and then fell. He also testified that he did see where Petitioner's right hand was during this incident. Mr. Silva explained that he observed Petitioner the entire time and he maintained that Petitioner put the box on the pallet, hesitated, and then fell. He explained that Petitioner did not exhibit any pain symptoms. He also testified that the box that Petitioner was lifting did not fall.

Rebuttal Testimony of Petitioner

Petitioner testified that she is 5'2 tall and that the boxes photographed in Respondent's Exhibit 7 are like the boxes with which she was working. Petitioner testified that on October 3, 2013 she is sure that she was stacking boxes seven levels high and the box that she was stacking was over her head at the seventh level.

ISSUES AND CONCLUSIONS

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

In support of the Arbitrator's decision relating to the admissibility of Respondent's Exhibit 9, the Arbitrator finds the following:

Petitioner objected to the admissibility of Respondent's Exhibit 9 based on either lack of foundation or the hearsay nature of the exhibit. Petitioner's objection on the basis of foundation is overruled. Petitioner's objection on the basis of the hearsay nature of the exhibit is sustained. Respondent's Exhibit 9 is a prior consistent statement. Respondent's Exhibit 9 is not admitted into evidence, but will remain with the Commission's file as a rejected exhibit.

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

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2011). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). Additionally, Petitioner must establish the "'arising out of' component [which] refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of her employment) to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

It is undisputed that Petitioner sustained an accident at work on May 4, 2011. AX1. The disputed issues of causal connection and Respondent's liability for payment of medical bills in that case are addressed in the concurrent decision issued in Case No. 11 WC 25277. In this case, Petitioner claims that she aggravated her pre-existing condition sustained as a result of her first accident at work while lifting a box onto a pallet on October 3, 2013. Respondent asserts that Petitioner did not sustain any accident at work on that date. After careful review of the record as a whole, the Arbitrator finds that Petitioner did sustain an injury at work on October 3, 2013.

Petitioner testified that she fell backwards onto the ground at work on October 3, 2013. She was sent for immediate medical care at the company clinic that day. Petitioner's reports to every other medical provider that she saw, as well as to Respondent's Section 12 examiner, Dr. Weber, is consistent to the extent that she was handling a box at work and placing it onto a pallet then, through some mechanism involving the box, she fell on the ground at work. This incident was witnessed by her supervisor, Mr. Silva. Based on the foregoing, the Arbitrator finds that Petitioner sustained an accident at work on October 3, 2013 as claimed.

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's condition of ill-being is causally related to the injury, the Arbitrator finds the following:

While Respondent asserts that Petitioner did not sustain a compensable accident, the issue rests squarely on whether Petitioner's fall to the ground at work is causally connected to any physical condition in either the neck, low back, bilateral upper extremities, bilateral lower extremities, or bilateral wrists as claimed. After careful review of the record as a whole, the Arbitrator finds that Petitioner's accident caused only a bilateral wrist sprain and lumbar sprain as opined by Respondent's Section 12 examiner, Dr. Weber. In so concluding, the Arbitrator does not find the testimony of Petitioner to be credible. Petitioner's testimony is controverted by the testimony of Mr. Silva as well as her own reports as reflected in the medical records.

Petitioner described the accident of October 3, 2013. She explained that she was working for Respondent and her arm was hurting her a little bit when she filled up a box that weighed 65-70 pounds and was placing it onto a skid stacked seven boxes high. Petitioner repeatedly maintained that the skid was stacked seven boxes high. She explained that she lifted up a particular box, but she felt pain in her hand and her hand was not stable after which the box came toward her and made her fall down. Of note, on cross examination Petitioner was unable to remember if the pain she experienced on October 3, 2013 was different from the pain that she felt in 2011 causing her to seek medical treatment. Regardless, according to Petitioner's testimony, she let the box go because her right hand did not "respond" and both she and the box fell. She explained that she fell onto her buttocks such that her hands and buttocks hit the floor. The testimony of Mr. Silva, who observed the incident, is quite different.

Mr. Silva testified that the boxes that Petitioner handled weighed an average of 30 pounds each when full. He knew this because he ordered 20,000 boxes every month. If Petitioner's testimony that she was handling 65-70 pounds is to be believed, she was placing two boxes of envelopes on a pallet overhead when she fell. Regardless of the accuracy of Petitioner's estimation of the weight of each box, Mr. Silva explained that the boxes were not supposed to be stacked seven levels high because the weight would crush the boxes on the bottom.

Mr. Silva also described the accident. He explained that it occurred while he was walking toward Petitioner's machine. At that time, he noticed her pick up a box and walk toward a center aisle. She lifted a box to her chest level on the skid, paused, then awkwardly and slowly went down to her left side and made a quick yelp. He testified that Petitioner landed on her left wrist and elbow. Mr. Silva explained that he was only 10 feet from Petitioner when he witnessed the incident and that he was located to her left. He took photographs of the particular skid the following day, which were submitted into evidence and showed boxes stacked five levels high with a section stacked only four levels high. On cross examination, Mr. Silva reiterated that Petitioner put the box on the pallet, hesitated and then fell. Of note, he also testified that the box that Petitioner lifted did not fall to the ground.

After careful consideration of the testimony, in light of the remainder of the record, the Arbitrator finds the testimony of Mr. Silva to be more credible than the testimony of Petitioner. Notwithstanding, Petitioner's own reports about the mechanism of injury, and the increase in reported symptoms and affected body parts during years while she was off of work, as documented in the medical records brings her credibility into further question. While some of Petitioner's recitation at the hearing about the mechanism of injury is corroborated by the medical records, the testimony of Mr. Silva taken in conjunction with the evolving mechanism of injury documented in the medical records paint an ever-changing picture not only of the mechanism of injury, but also of the body parts affected by the fall at work.

Initially, on October 3, 2013, Dr. Sisson noted a relatively consistent report from Petitioner that "...she was lifting a box up onto an overhead area when she experienced pain in her right wrist that resulted in her losing control of the box, which then began to fall and she attempted to arrest that fall using her hands." She reported bilateral wrist pain that radiated up her arms toward her shoulders, but no neck or low back pain.

Petitioner testified that the following day, on October 4, 2013, she was in such a condition that she could not get out of bed. She did not go to work thereafter. After her one time, second opinion visit to Dr. O'Keefe on April 9, 2013 after her repetitive trauma injury in 2011, Petitioner returned to his office on October 8, 2013. Petitioner's report about the mechanism of injury on October 3, 2013 was documented in a handwritten note. Specifically, that Petitioner "went to move 60# box of paper that was above her head for the machine to make envelopes, felt her (R) hand give and the box fell off, patient fell into a seated position hitting buttox + using both hands to break her fall." Dr. O'Keefe's assistant, Ms. Kirsch, PA-C, also noted Petitioner's report that "[s]he was injured on 10/03/13 when she was moving a 60 lb. box that was stacked higher than her head to load it into the machine. She felt her right wrist give way as she was trying to move the box, causing her to lose balance. The box fell onto the cement floor to her left and she fell backwards onto her buttocks into a seated position. She used her two hands to break her fall on either side of her. ... She also has a history of bilateral wrist tendinitis in 2011 that was treated by Dr. Vendor. She states her wrist pain was virtually resolved until the injury at work 10/03/13 re-aggravated those problems. She has no prior history of back pain or pathology." Notably, Petitioner's report to Ms. Kirsch that her bilateral wrist pain had resolved is contrary to her report to Dr. Sisson on October 3, 2013 that her previous wrist pain "never got better." Regardless, Petitioner did not report any neck pain or shoulder pain to Ms. Kirsch.

When Dr. O'Keefe first saw Petitioner on October 17, 2013 he noted a history that "[h]er job as a machine operator and envelope manufacturer requires that she work at a very rapid pace. 15x an hour she lifts 50-60 lb. loads. They stack boxes well above the height of her head with that load. On 10/03/13, she was up on her toes trying to shove a box mostly with her right shoulder up above her head (it was the 7th row). Her arm popped with pain. The box fell towards her chest, knocking her to the ground. She fell backwards onto the concrete with her arms hyperextended. She had intense pain in her back, right shoulder, and both hands at that point." Dr. O'Keefe immediately provided an opinion that Petitioner's physical condition—as he found it on that date—was related to her fall at work.

Petitioner continued to see Dr. O'Keefe through 2016. At each visit, Dr. O'Keefe noted Petitioner's report of the mechanism of injury and her reported symptoms. By the time she last saw him on March 31, 2016, Dr. O'Keefe had opined that Petitioner's cervical spine, bilateral upper extremity, bilateral wrist, lumbar spine, bilateral lower extremity and myofascial symptoms as well as her gastrointestinal intolerance for medications were all related to the fall at work on October 3, 2013. A review of the mechanism of injury as reported by Petitioner to Dr. O'Keefe, Dr. O'Keefe's physician's assistant, the physicians at the company clinic, Dr. Chunduri, Dr. Hassan and Dr. Sokolowski reflect an increase in Petitioner's description about the intensity of the fall with injury to or symptoms in additional and fluctuating body parts as her treatment progressed. With her increasingly complex subjectively reported symptomatology, Dr. O'Keefe offered a corollary opinion that the symptoms and affected body parts were related to the fall at work despite negative diagnostic test results or minimal findings related to the neck and low back, which he nonetheless maintained were traumatically induced at work.

Ultimately, Dr. O'Keefe diagnosed Petitioner with some combination of bilateral wrist sprains, a lumbar sprain, traumatic bilateral carpal tunnel syndrome, cervical and lumbar disc injuries with associated bilateral

radiculopathy into both upper and lower extremities, DeQuervain's syndrome and a scapholunate and/or TFCC tear in one or both wrists as a result of her fall at work. Dr. O'Keefe refuted the proposition that Petitioner had any pre-existing condition in the wrists—or elsewhere—that were not caused by the October 3, 2013 fall and, if she did, that they were aggravated by the incident at work. However, Dr. O'Keefe's opinions reflect a desire to treat the subjectively reported symptoms of a patient whose reliability as a historian has been previously questioned by her own treating physician, Dr. Vender, and whose subjective reports could not be corroborated by the overwhelming majority of repeatedly administered diagnostic tests. The diagnostic tests that produced some pathology, such as in the cervical spine and lumbar spine, were mild and can be attributed to degenerative changes as noted by Dr. Weber. Even Dr. Sokolowski declined to ordered treatment to the neck in contravention of Dr. O'Keefe's steadfastly maintained opinion to that point that Petitioner sustained severe and traumatic discal injuries as a result of the fall at work. It was only after evaluation by Dr. Sokolowski that Dr. O'Keefe noted that Petitioner's previously severe cervical condition was uncorroborated by the then "not horribly abnormal" cervical MRI. The Arbitrator finds the opinions of Dr. O'Keefe in this case to be wholly unpersuasive and assigns them no weight.

Petitioner also relies on the opinions of Dr. Sokolowski in support of her claims. However, his opinions are based on an inaccurate history, at best. Dr. Sokolowski relied on a history that Petitioner was lifting a 60 pound box onto a skid above eye level when she developed a shooting pain from her wrist through her right arm to her neck as well as left-sided hand pain and, as the box started to slip, she lost her balance and fell backwards landing on her buttocks, catching herself on the ground with both arms. Petitioner's report to Dr. Sokolowski is controverted by her own reports to other medical providers. She did not report an onset of neck pain or left-sided hand pain to either Dr. Sisson, Dr. O'Keefe's physician's assistant, Ms. Kirsch, or Dr. O'Keefe. Moreover, on cross-examination, Dr. Sokolowski also acknowledged that Petitioner had pre-existing pathology (i.e., disc desiccation) at L3-L4 and L4-L5. He also acknowledged that it was not typical for a left-sided herniation to cause symptoms on the right side, but explained that Petitioner had central and left-sided herniation so there was a reasonable expectation of bilateral nerve root involvement. Such an opinion might be plausible, but not in light of his understanding of the mechanism of injury as reported by Petitioner which are controverted by her own reports to others. With regard to the cervical spine, Dr. Sokolowski initially testified that Petitioner's condition was causally related to the fall at work, but later acknowledged that the etiology of Petitioner's cervical symptoms was unclear. Based on all of the foregoing, the Arbitrator does not find the opinions of Dr. Sokolowski in this case to be persuasive and assigns them no weight.

The more plausible medical opinions in this case were rendered by Respondent's Section 12 examiner, Dr. Weber, who provided reasonable explanations supported by objective medical evidence. Dr. Weber diagnosed Petitioner with bilateral wrist sprains and lumbar back sprain. In so concluding, she also noted that Petitioner's reported mechanism of injury changed throughout the medical records. She explained that Petitioner presented to her with no objective findings or abnormalities on physical examination and determined that Petitioner's subjective complaints did not correlate with objective clinical findings.

At her deposition, Dr. Weber testified that Petitioner's bilateral wrist MRI reports suggested chronic scapholunate abnormality and preexisting degenerative changes, which were not related to her fall at work. She acknowledged that a fall could aggravate scapholunate or TFCC tears, but explained that Petitioner had no tenderness over the TFCC and provocative testing of the TFCC did not reproduce any symptoms. Dr. Weber also testified that she did not diagnose Petitioner with carpal tunnel syndrome because Petitioner "had no findings that would suggest carpal tunnel in the sense that she had negative Tinel's and negative Phalen's bilaterally at the wrist[]" with no evidence of atrophy. She further explained she did not diagnose Petitioner with DeQuervain's syndrome because Petitioner did not have an unequivocal Finkelstein's and, regardless, the

described mechanism of injury would not have caused it. Ultimately, Dr. Weber maintained that Petitioner's medical records and physical presentation at the time of the independent medical evaluation was wholly subjective and did not correlate to any objective findings other than a mild wrist and lumbar back strain. Dr. Weber testified that "there is a suggestion of non-physiological causes for ongoing subjective complaints as her exam was normal."

Although Dr. Weber only examined Petitioner on one occasion, her explanations correspond to objective medical evidence. Dr. Weber's opinions are also buttressed by the inability of two of Petitioner's own treating physicians, Drs. Vender and Sokolowski, to determine the cause of her symptoms whether it related to the bilateral wrists after the 2011 accident or the cervical spine after the 2013 accident. Dr. Weber did not examine Petitioner with regard to the cervical spine, but Dr. Sokolowski could not determine the etiology of her cervical complaints. In this case, objective diagnostic tests and Petitioner's clinical presentation throughout treatment simply do not correspond to her confusing and increasing subjectively reported symptomatology coupled with an increasingly volatile and severe accident. In the absence of clearly, contemporaneously and consistently reported symptoms in specific body parts plausibly resulting from an accident, which in this case was awkward and mild as witnessed by Mr. Silva, there is insufficient credible evidence to rely on the opinions of treating physicians who relied primarily on a poor historian's reports and her ongoing diffuse complaints to render treatment. The Arbitrator opinions of Dr. Weber to be persuasive.

Based on all of the foregoing, the Arbitrator finds that Petitioner has established a causal connection between her accident at work and current condition of ill-being to the extent opined by Dr. Weber; namely, that she sustained bilateral wrist sprains and a low back sprain.

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:

Petitioner claims entitlement to payment of reasonable and necessary medical bills from medical providers that administered care after her accident at work. As explained above, the opinions of Dr. O'Keefe and Dr. Sokolowski are not persuasive. With regard to her medical treatment, the Arbitrator does not find that the treatment rendered to Petitioner is reflective of reasonable or necessary medical treatment to alleviate her of the effects of the injury she sustained. In so concluding, the Arbitrator relies on the opinions of Dr. Weber as well as the utilization reviews submitted into evidence. As opined by Dr. Weber, Petitioner suffered a lumbar strain and bilateral wrist strains as a result of the October 3, 2013 work accident. Treated conservatively, Petitioner's care should have ended approximately six weeks later as opined by Dr. Weber ending on November 13, 2013 at the latest. Therefore, the Arbitrator finds that any medical treatment rendered after November 13, 2013 is neither reasonable, necessary, nor related to the work accident. Petitioner's claim for payment of any medical bills after November 13, 2013 is denied.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical treatment, the Arbitrator finds the following:

As explained above, the opinions of Dr. O'Keefe and Dr. Sokolowski are not persuasive. With regard to her medical treatment, the Arbitrator does not find that the treatment rendered to Petitioner is reflective of reasonable or necessary medical treatment to alleviate her of the effects of the injury she sustained. In so concluding, the Arbitrator relies on the opinions of Dr. Weber that Petitioner sustained bilateral wrist sprains and a low back sprain. The prospective treatment recommended by Drs. O'Keefe and Sokolowski is denied.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

Petitioner requests temporary total disability benefits from October 4, 2013 through April 12, 2016. "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." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (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*, 2014 IL App (3d) 130028WC at *28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work*. *Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

As explained above, the opinions of Dr. O'Keefe and Dr. Sokolowski are not persuasive. With regard to her medical treatment, the Arbitrator does not find that the orders placing Petitioner off work or on light duty is reflective of the injury that Petitioner sustained— bilateral wrist sprains and a low back sprain. In reliance on the opinions of Dr. Weber, the Arbitrator finds that Petitioner was temporarily totally disabled from October 4, 2013 through November 13, 2013 and denies[5] any claim for temporary total disability benefits thereafter.

[5] In addition, the Arbitrator notes that Petitioner is not entitled to temporary total disability benefits from January 6, 2014 through May 19, 2014 as claimed. Petitioner failed to comply with Respondent's request that she submit to an examination pursuant to Section 12 of the Act. Section 12 states that "[i]f the employee refuses so to submit himself to examination or unnecessarily obstructs the same, his right to compensation payments shall be temporarily suspended until such examination shall have taken place, and no compensation shall be payable under this Act for such period." 820 ILCS 305/12. Petitioner was initially unable to recall at the hearing why she failed to appear for the exams and the evidence reflects an explanation on one occasion from Petitioner's prior attorney that she encountered bad weather. The foregoing, in light of Petitioner's unreliable testimony, is insufficient to adequately explain her repeated failure to comply with Respondent's request pursuant to Section 12 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

JOHN LIZON,

Petitioner,

vs.

NO: 09 WC 43267

18IWCC0299

POST GENERAL CONTRACTORS, LLC,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h) OF THE ACT

This matter comes before the Commission pursuant to Respondent's Section 19(h) Petition. A hearing was held before Commissioner Michael J. Brennan on January 10, 2018. After reviewing the record in its entirety and being advised of the facts and applicable law, the Commission hereby denies Respondent's Section 19(h) Petition and finds that Respondent failed to establish that Petitioner's condition has diminished since the time of the original decision of the Commission.

Procedurally, this matter was tried before Arbitrator Lynette Thompson-Smith on August 21, 2015. The Petitioner was employed by Respondent as a superintendent. His job required him to "run all trades, take care or job conditions and anything else that was not covered by the subcontractors." Petitioner was injured on May 14, 2009 when the ladder he was working on collapsed. He fell to the ground and injured his left shoulder and left hand. He sustained a non-displaced fracture of the acromial end of the left distal clavicle.

Petitioner underwent the following surgeries as a result of his injuries: 1) open reduction and internal fixation of the left distal radius fracture on May 19, 2009; 2) removal of the hardware on October 19, 2009; 3) left tenosynovectomy of the digital flexor tendon as well as a carpal tunnel release on February 25, 2010; and, 4) left median nerve decompression and carpal tunnel release on July 17, 2012.

Petitioner was ultimately released to full-duty work relative to his left shoulder. However, as to the left hand, he received permanent restrictions placing him at the sedentary to light physical demand level with a 20-pound lifting restriction from the floor to 31 inches, and 10-pounds from the floor to 61 inches. He could carry 20 pounds up to 100 feet, push and pull 25 to 35 pounds. He could climb ladders up to 8 feet. The Respondent did not accommodate his restrictions.

In her Decision dated December 7, 2015, the Arbitrator found Petitioner failed to prove that he was permanently and totally disabled as a result of his accident. The Arbitrator found that Petitioner sustained a loss of trade under Section 8(d)(2) and awarded him 50% loss of use of the man-as-a-whole, along with maintenance benefits, temporary total disability benefits, and penalties pursuant to Section 19(k), Section 19(l), and Section 16 of the Act.

In its Decision dated October 25, 2016, the Commission modified the Decision of the Arbitrator by vacating the award of penalties and modifying the award of maintenance benefits. All else was affirmed and adopted including the award of 50% loss of use of the man-as-a-whole, for an apparent loss of trade under Section 8(d)(2).

Subsequently, Respondent filed a 19(h) petition on November 21, 2016 and a hearing was held January 10, 2018. Respondent's witnesses, Mary Reyes (HR Manager for Hispanic Housing Development) and Robin Valenzuela (investigator) testified at hearing. Ms. Reyes testified pursuant to subpoena. The Petitioner did not testify.

Ms. Reyes is the HR manager for Hispanic Housing Development, which builds affordable housing. T.6. They also have a subsidiary company, Tropic Construction. Ms. Reyes stated that Tropic Construction has 11 employees including the Petitioner. T.8. Ms. Reyes testified that Petitioner filled out an application for employment on September 5, 2015 and was hired as a Field Superintendent on September 21, 2015. T.14, RX.4. Ms. Reyes testified that Petitioner's application indicated that he worked for Projex Construction from July 2014 through the present. T.15., RX.4.

Ms. Reyes testified that the Field Superintendent manages the project and it is not a desk job. T.18. She stated that Petitioner never asked for a reasonable accommodation and never indicated that he had prior permanent restrictions. T.20. She did not know if he physically moved or unloaded material. T.21. She stated that the job description for a Field Superintendent does not list specific lifting requirements. T.22. She testified that Petitioner never indicated any problems performing his job. T.23. He would not be required to use tools and she did not see him lift more than 20 pounds. T.26.

Per the job description, a Field Superintendent is responsible for day-to-day management, implementation and coordination of construction projects. The job description does not indicate a lifting requirement. RX.4.

The Respondent obtained surveillance of the Petitioner. The Commission reviewed the surveillance video in its entirety. Specifically, portions of the video capture Petitioner loading wood 2x4s from a cart into his truck. He loads 2 2x4s at one time and 3 2x4s another time. Petitioner was also seen carrying grocery bags from his truck to his house. He was seen lifting a dog into his car with two hands. RX.1, RX.2, RX.3. We have no evidence as to the weight of any of the items that Petitioner is seen lifting.

Robin Valenzuela is a Private Investigator for Combined Investigators. T.29. He conducted surveillance between December 23, 2016 through February 2017. T.34. He testified that he performed surveillance at the wrong address on December 23, 2016. T.35. Mr. Valenzuela identified Petitioner in the court room and stated that Petitioner weighed about 200 pounds. It was noted that Petitioner weighed 260 pounds. T.40. Mr. Valenzuela noted that Petitioner had a ladder on his work truck. He estimated the ladder to weigh between 30 to 40 pounds. T.45. He saw Petitioner use a measuring tape, and lift numerous grocery bags on February 25, 2017. He did not know what was in the grocery bags. T.69. He also saw Petitioner lift a dog on December 24, 2016. He did not know the weight of the dog. T.64. He did not see Petitioner carry anything known to be over 20 pounds. T.67.

Prior to the first arbitration hearing, Petitioner underwent an FCE on November 29, 2012. Per the FCE, Petitioner could function in the sedentary to light level of work. He had no limitation with respect to standing, walking, sitting, balancing, stooping, crouching, or climbing. He was limited to lifting 20-pounds from floor to 31 inches and 10-pounds from floor to 61 inches. He could carry 20 pounds up to 100 feet, push and pull 25 to 35 pounds, and climb a ladder up to 8 feet.

Respondent obtained a Section 12 examination from Dr. Kevin Walsh of Orthopaedics Bone, Joint and Spine Center on February 14, 2017. Petitioner reported that his hands were still killing him. He worked as a site supervisor and 95% of his job was paperwork. Petitioner reported that his hand would go numb and his fingers hurt. He has had constant pain since his injury and his symptoms are worse now. Examination revealed full extension of his digits and full flexion. Petitioner had a negative Tinel's and Phalen's test. He had 5/5 motor strength in grip, wrist extension, and wrist flexion. He had 70 degrees of dorsiflexion and 80 degrees of flexion. There were no arthritic changes visible. Dr. Walsh watched the surveillance video and opined that Petitioner did not require any ongoing permanent limitations or restrictions. Dr. Walsh noted that Petitioner had an objectively normal physical examination despite his subjective complaints, and the surveillance evidence appeared to show him working beyond his prior FCE restrictions. Permanent restrictions were not reasonable at this time. RX.5.

In *Gay v. Industrial Commission*, 178 Ill. App. 3d 129, 132 (1989), the Illinois Supreme Court explained that:

> [t]he purpose of a proceeding under section 19(h) is to determine if a petitioner's disability has "recurred, increased, diminished or

> ended" since the time of the original decision of the Industrial Commission. (Ill. Rev. Stat. 1985, ch. 48, par. 138.19(h); *Howard v. Industrial Comm'n* (1982), 89 Ill. 2d 428, 433 N.E.2d 657). To warrant a change in benefits, the change in a petitioner's disability must be material. (*United States Steel Corp. v. Industrial Comm'n* (1985), 133 Ill. App. 3d 811, 478 N.E.2d 1108.) In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed materially since the time of the Industrial Commission's first decision. (*Howard*, 89 Ill. 2d 428, 433 N.E.2d 657.) Whether there has been a material change in a petitioner's disability is an issue of fact, and the Industrial Commission's determination will not be overturned unless it is contrary to the manifest weight of the evidence. *Howard*, 89 Ill. 2d 428, 433 N.E.2d 657; *United States Steel Corp.*, 133 Ill. App. 3d 811, 478 N.E.2d 1108.

By its Statement of Exceptions, the Respondent argues that the prior award of 50% MAW should be reduced to 55% loss of use of the left hand and 5% MAW as Petitioner is no longer precluded from pursuing his usual and customary line of employment. He is now working as a Field Superintendent and earns more than before the accident. In further support of lowering the award, the Respondent relies on Dr. Walsh's Section 12 opinion that Petitioner's examination was normal and there was no evidence of a disability.

The Commission has fully examined Respondent's evidence including the surveillance video. The Commission is not persuaded by Respondent's argument that the video shows that Petitioner's condition has materially decreased and that he can function without limitation.

The vast majority of the video shows the Petitioner performing normal activities including walking and standing around various job sites. He is also seen carrying grocery bags, lifting a dog, and lifting 2x4s. However, Petitioner has no restriction relative to walking or standing. And, the Respondent offered no evidence as to the weight of the 2x4, the weight of the dog, or the weight of grocery bags.

Furthermore, Respondent's argument that his Field Superintendent position demonstrates a material decrease in his medical condition is equally as unpersuasive. The job description for a Field Superintendent does not contain a lifting requirement. Respondent's witness testified that she did not know if Petitioner had to lift at work and further testified that she has not seen him lift over 20 pounds. Respondent's argument fails to demonstrate a material decrease in Petitioner's medical condition.

The Commission finds Dr. Walsh's report as to a material decrease in Petitioner's condition not persuasive. While Dr. Walsh commented that Petitioner's examination was normal, his opinion

18IWCC0299

was premised, in part, upon the surveillance video. As stated above, the Commission finds no evidence contained within the surveillance video demonstrating that Petitioner was working outside of his permanent restrictions. Effectively, Dr. Walsh's opinion is the same as the opinion he rendered at trial.

The Commission finds that Respondent failed to provide credible evidence that Petitioner's medical condition has materially decreased since the original Commission decision. Accordingly, Respondent's 19(h) Petition is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Section 19(h) Petition is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $800.00 per week for a period of 141-4/7 weeks, from December 4, 2012 through August 21, 2015, in maintenance benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $664.72 per week for 250 weeks (less permanent partial disability credit of $7,200.00), because the injuries sustained resulted in permanent partial disability of 50% loss of use of the person as a whole, as provided in Section 8(d)(2) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $148,457.14 for temporary total disability benefits, $100,571.45 for maintenance benefits and $7,200.00 as a permanent partial disability advance for other benefits, for a total credit of $256,228.59.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,300.00. 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: MAY 9 – 2018

Michael J. Brennan

Thomas J. Tyrrell

MJB/tdm
D: 5-1-18
052

Kevin W. Lambern

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Phillip Griffin,
Petitioner,

vs.

NO: 11 WC 34831

Schatz Building LLC,
Respondent.

18IWCC0300

DECISION AND OPINION ON REMAND

This case now comes before the Commission on the Respondent's review of the December 5, 2016 order of Arbitrator Thompson-Smith denying the Respondent's Motion to Dismiss.

This case has a procedural history that is at best convoluted, bordering on torturous, and which was well laid out in the Arbitrator's order, which is attached hereto and made a part hereof.

As the Arbitrator noted, it is arguable that the circuit court did not appropriately exercise its designated statutory powers when it vacated the original determination in this case (see case reference number 13 IWCC 0163). Moreover, this Commission panel does not concur with Judge Cepero's assessment that there was no proper weighing of the evidence by either the prior Arbitrator or the reviewing Commissioners, and further disputes that there was any improper motive or "attempt to insulate them from judicial review" (see Sept. 24, 2013 order in 13 L 50215). However, these issues are for a reviewing court, not the Commission, to determine, and the Commission is not free to disregard a reviewing court's order. See *Terry Noonan v Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC, "Where a cause is remanded by a court of review to a lower court with directions to enter a certain order or decree, the latter court has no discretion but to enter the decree as directed." *Id.*, internally citing *Northwestern University, v. Industrial Comm'n*, 409 Ill. 216, 219, 99 N.E.2d 18, 20 (1951) and *People ex rel. Campo v. Matchett*, 394 Ill. 464, 469, 68 N.E.2d 747, 749 (1946).

The Arbitrator's order is affirmed and adopted and this case is hereby remanded to the arbitration level for a new hearing in accord with the aforementioned Circuit Court order.

IT IS THEREFORE ORDERED BY THE COMMISSION that this matter shall be remanded and assigned to an Arbitrator for hearing.

18IWCC0300

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: MAY 11 2018

Joshua D. Luskin

o-01/30/18
jdl/ac
68

Charles J. DeVriendt

DISSENT

I respectfully dissent. I believe the Majority in rendering its decision failed to address the jurisdictional aspect of Respondent's review. This matter comes before the Commission on Respondent's review of the December 5, 2016 decision entered by Arbitrator Lynette Thompson-Smith denying Respondent's Motion to Dismiss.

Procedural History

The parties proceeded to hearing before Arbitrator Kelmanson who issued a decision on May 31, 2012 denying benefits. Petitioner timely filed a Petition for Review. On February 15, 2013, the Commission entered a decision affirming and adopting the Arbitrator's decision with one Commissioner dissenting. Petitioner timely appealed to the circuit court of Cook County. On September 24, 2013, the Honorable Robert Lopez Cepero entered an order vacating the decision of the Commission and remanding the matter to the Commission with directions.

In the interim, Respondent filed an appeal to the Appellate Court pursuant to Supreme Court Rule 306(a)(6) which was denied on November 27, 2013. Thereafter, the parties filed respective motions before the Commission for the matter to be heard pursuant to the September 24, 2013 remanding order of the Honorable Robert Lopez Cepero. On February 10, 2014, a hearing was undertaken before the Commission which issued its unanimous decision on February 11, 2015. (In Arbitrator Thompson-Smith's decision of December 5, 2016 she notes one Commissioner strongly dissented, but this statement appears to describe the Commission's decision dated February 15, 2013). No appeal was perfected pursuant to Section 19(f)(1) of the Act by either party.

On or about, February 27, 2015, Petitioner filed a motion before the Honorable Robert Lopez Cepero to enforce the Order of September 24, 2013. The matter was set for hearing on March 25, 2015; pursuant to the transcript of hearing, the Honorable Robert Lopez Cepero found the Commission in contempt and ordered Commissioners Donohoo, Gore, and White (the three Commissioners who signed the February 11, 2015 decision) to appear on April 8, 2015 for a Rule to Show Cause. On April 3, 2015, the Commission entered an Order on Remand from the Circuit Court vacating its prior decision of January 14, 2015 (no such decision exists and presumably the referenced date is a scrivener's error and relates to the February 11, 2015 decision) and remanding the matter to the Arbitrator for a new hearing. On April 7, 2015, an Emergency Motion to Vacate the March 25, 2015 Order was filed by the Attorney General, and after several continuances and hearings, it appears any potential contempt citation was vacated.

On April 21, 2015, Respondent filed an appeal pursuant to Section 19(f)(1) of the Act regarding the Commission's decision of April 3, 2015. On July 14, 2015, the Honorable Carl Anthony Walker consolidated the matters (2013 L 50215 and 2015 L 50295) and transferred the same to the Honorable Robert Lopez Cepero for disposition. On August 6, 2015, the Honorable Lopez Cepero conducted a hearing on Respondent's Motion to Certify Questions pursuant to Supreme Court Rule 308(a) and Motion to Remand to Commission without Additional Evidence which were entered and continued on several occasions. Following the retirement of the Honorable Robert Lopez Cepero in October of 2015, the matters were reassigned to the Honorable Edmund Ponce de Leon. Thereafter, Petitioner filed a Motion to Dismiss for Lack of Jurisdiction. All matters were briefed and argued before the Honorable Edmund Ponce de Leon who entered an order on December 15, 2015 granting Petitioner's Motion to Dismiss for Lack of Jurisdiction and dismissing all other motions by both parties for a lack of jurisdiction. The circuit court subsequently remanded the matter to the Commission.

Thereafter, the matter was set before Arbitrator Thompson-Smith at the Commission. Respondent filed a Motion to Dismiss predicated on Petitioner's failure to perfect its review of the Commission's decision of February 11, 2015. The parties fully briefed the matter and conducted arguments on September 27, 2016. On December 5, 2016 Arbitrator Thompson-Smith entered her decision denying Respondent's Motion to Dismiss. The December 5, 2016 decision is the subject of the present review.

Conclusions of Law

1. December 15, 2015 Order of the Honorable Edmund Ponce de Leon

Initially, the Commission must examine the remanding order from the circuit court in order to determine the mandate of the reviewing court. "'The trial court may only do those things directed in the mandate.' [Citation omitted]." *Quincy School District No. 172 v. Ill. Educ. Labor Rels. Bd.*, 366 Ill. App. 3d 1205, 1209, 853 N.E.2d 440 (2006). The circuit court remanded the matter to the Commission following its order of December 15, 2015. In its December 15, 2015 order, the circuit court dismissed all pending matters regarding consolidated cases 2013 L 50215 and 2015 L 50295 based on a lack of jurisdiction. Therefore, the Commission must review the decisions it previously entered.

2. Commission's Decision dated April 3, 2015

The Commission entered the April 3, 2015 "corrected decision" labeled as "Order on Remand from the Circuit Court" 51 days after its initial decision on remand dated February 11, 2015. Section 19(f) of the Act states:

> The decision of the Commission acting within its powers, according to the provisions of paragraph (e) of this Section shall, in the absence of fraud, be conclusive unless reviewed as in this paragraph hereinafter provided. However, the Arbitrator or the Commission may on his or its own motion, or on the motion of either party, correct any clerical error or errors in computation within 15 days after the date of receipt of any award by such arbitrator or any decision on review of the Commission and shall have the power to recall the original award on arbitration or decision on review, and issue in lieu thereof such corrected award or decision. 820 ILCS 305/19(f) (West 2013).

The Commission filed its "corrected decision" well beyond the 15-day time limit as defined by the Act. The matter of *Domagalski v. The Industrial Commission*, 97 Ill. 2d 228, 454 N.E.2d 295 (1983), is directly on point. In *Domagalski*, the Commission filed its original decision on February 4, 1976. Thereafter, it filed its "corrected decision" on February 23, 1976 reversing its original decision relating to accident. The Supreme Court held the "corrected decision" had no legal effect as it was void. Specifically, the Court held "The February 27, 1976, decision was therefore of no effect. When the Commission filed its 'corrected decision,' it had already lost jurisdiction of the case." *Id.* at 234-235. The Commission is an administrative body and can only act in conformity with the Act. Any action taken outside the parameters of the Act is void. *Siddens v. Industrial Commission*, 304 Ill. App. 3d 506, 711 N.E.2d 18 (1999). The Commission's decision of April 3, 2015 is void.

3. Commission's Decision dated February 11, 2015

Thusly, the Commission must examine its decision of February 11, 2015 which requires a review of the circuit court's order of September 24, 2013. To that end, Petitioner timely filed an appeal pursuant to Section 19(f)(1) of the Act of the Commission's February 15, 2013 decision affirming and adopting the decision of the Arbitrator denying causation with one Commissioner dissenting. In the order of September 24, 2013, the Honorable Robert Lopez Cepero vacated the decision of the Commission and remanded the matter with instructions- specifically a new hearing was to be undertaken to allow the Commission to weigh evidence and provide its reasoning accordingly. "'The trial court may only do those things directed in the mandate.' [Citation omitted]." *Quincy School District No 172 v. Ill. Educ. Labor Rels. Bd.*, 366 Ill. App. 3d 1205, 1209, 853 N.E.2d 440 (2006).

As directed by the circuit court, a hearing was conducted on February 10, 2014, and the Commission entered its decision on February 11, 2015 providing additional reasoning and again affirming and adopting the May 31, 2012 decision of the Arbitrator. In its decision, though, the Commission expressed opinions as to the circuit court's legal authority pursuant to Section 19(f)(2) of the Act. It is certainly acknowledged by this Commission, its frustration notwithstanding, "[n]o matter how defective the circuit court's reasoning may have been, the Commission was charged with following the court's order..." *Noonan v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC, ¶11. As such, the Commission's discussions and/or conclusions as it

relates to the underlying validity of the circuit court's September 24, 2013 order is void for a lack of jurisdiction as such are outside the scope of the mandate. *Fleming v. Moswin*, 2012 IL App (1st) 103475-B (matter was remanded to the trial court for sole purpose of conducting a *Batson* hearing and the portion of the trial court's order which went beyond the reviewing court's mandate is void).

As for the Commission's decision of February 11, 2015, it was not appealed by either party pursuant to Section 19(f)(1) of the Act. "The jurisdiction of the circuit court to review a decision of the Industrial Commission under the Workmen's Compensation act is wholly statutory, and its power, in the exercise of this special statutory jurisdiction is limited by the provisions of the statute. [Citation Omitted]." *Thompson v. Industrial Commission*, 377 Ill. 587, 589, 37 N.E.2d 350 (1941). Unlike in other administrative hearings, the circuit court does not retain jurisdiction once the matter is remanded to the Commission. *Kudla v. Industrial Commission*, 336 Ill. 279, 168 N.E. 298 (1929). In *Kudla*, the circuit court remanded the matter to the Commission with directions to take further evidence. As part of the remand order, the circuit court specifically stated it retained jurisdiction. *Id.* at 280. The Supreme Court of Illinois disagreed. On review, the Supreme Court noted "The court having exhausted the jurisdiction conferred on it by statute, its attempt to retain further jurisdiction is void." *Id.* at 282. The Supreme Court held "The writ of *certiorari* authorized by this section [Section 19(f) of the Act] is the only method provided for the review of decision of the Industrial Commission." *Id.* at 281. As such, Petitioner's filing on February 27, 2015 of a Motion to Enforce the Order of September 24, 2013 did not confer jurisdiction on the circuit court, thereby rendering the Commission's decision of February 11, 2015 the final decision.

4. Voidable vs. Void

Lastly, the Commission must review its jurisdiction.

> The term "jurisdiction," while not strictly applicable to an administrative agency, may be employed to designate the authority of the agency to act. In administrative law, the term "jurisdiction" has three aspects: (1) personal jurisdiction, (2) subject-matter jurisdiction, and (3) the agency's scope of statutory authority. [citation omitted]. A judgment or order is void where it is entered by a court or agency which lacks personal jurisdiction, subject-matter jurisdiction, or the inherent power to enter the particular judgment or order, or where the order is procured by fraud. *Siddens v. Industrial Commission*, 304 Ill. App. 3d 506, 510-511, 711 N.E.2d 18 (1999).

The Commission in rendering its decision on February 11, 2015 possessed jurisdiction over the parties and the subject matter. A question exists as to whether it possessed "the inherent power to enter the particular judgment or order..." *Id.* Stated another way, did the Commission abide by the circuit court's mandate (directions) when entering its decision on February 11, 2015? If not, is the decision of February 11, 2015 voidable or void.

The Supreme Court in the matter of *In re Marriage of Mitchell*, 181 Ill. 2d 169, 692 N.E.2d 281 (1998), examined the distinction between voidable and void orders. There, the trial court possessed jurisdiction of the parties as well as jurisdiction over the dissolution proceedings but entered an order contrary to the statute. The Court found the order to be voidable and not subject to collateral attack. In discussing the distinction between voidable and void, the Court noted

"'Accordingly, a court may not lose jurisdiction because it makes a mistake in determining either the facts, the law or both.' *Davis, 156 Ill. 2d at 156*." *Id.* at 175.

This Commissioner believes the Commission followed the mandate (directions) contained in the circuit court's order of September 24, 2013 in rendering its decision of February 11, 2015. If such is not the case, the Commission's February 11, 2015 decision is voidable. "When the trial court's action on remand is inconsistent with the reviewing court's mandate, it is subject to reversal on appeal. [Citation omitted]." *Ertl v. City of De Kalb*, 2013 IL App (2d) 110199, ¶21. No appeal was taken in conformity with Section 19(f)(1) of the Act. As such the Commission's decision of February 11, 2015 is final and conclusive. It is not lost on this Commissioner that the determination of voidable and void as it relates to its own decisions may be more appropriate for the Appellate Court, but this Commissioner believes such determination was necessary in order to address Respondent's review.

Accordingly, I would vacate Arbitrator Thompson-Smith's decision of December 5, 2016, and grant Respondent's Motion to Dismiss. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
)
COUNTY OF COOK)

18IWCC0300

ILLINOIS WORKERS' COMPENSATION COMMISSION

ORDER

PHILLIP GRIFFIN
Employee/Petitioner
v.
SCHATZ BUILDING LLC,
Employer/Respondent

Case # 11 WC 34831

The Respondent filed a Motion to dismiss this matter and properly served all parties. The Petitioner filed its Response to Respondent's Motion to Dismiss on August 25, 2016 and the Respondent filed its Reply to Petitioner's Response on September 8, 2016. This matter came before me in the city of Chicago, on September 27, 2016, for oral argument. After hearing the parties' arguments and deliberations; and reviewing the case file and relevant case law, I hereby deny the Respondent's Motion to Dismiss. A record of the hearing was made.

FINDINGS OF FACT

It is this Arbitrator's opinion that whether the Respondent's Motion should be granted or not depends solely on the procedural underpinnings of this matter. As such, it is important to understand how this matter came before an Arbitrator for a second time.

Procedural History in relevant part

This matter was initially heard before Arbitrator Kelmanson, who issued a decision on May 31, 2012, denying benefits because she found no causal connection between the Petitioner's current state of ill-being and his accident. That decision was timely reviewed on June 19, 2012; and the Commission, after considering the sole issue of causal connection, affirmed and adopted the Decision of the Arbitrator on February 15, 2013, with one Commissioner dissenting. A timely review of the Commission's decision was filed on March 1, 2013 and on September 24, 2013; Judge Robert Lopez Cepero entered an Order vacating the Decision of the Commission/Arbitrator and remanded the matter to the Commission, for a new hearing on all issues.

The Respondent/Appellant, Schatz Building, LLC, requested leave to file an appeal of this Order, which relief was denied by the Appellate Court of the First District on November 27, 2013.
On January 8, 2014, Respondent/Appellant filed with the Commission a Motion for Action on Circuit Court Order for New Hearing on All Issues; a hearing was held by Commissioner Stephen Mathis on February 10, 2014.

According to file documents, on January 14, 2015, the Commission issued its Decision and Order on Remand, wherein it again affirmed the Decision of the Arbitrator, declaring potions of Judge Cepero's Order to be "null and void". The Arbitrator notes that there was no decision by the Commission dated January 14, 2015. The Commission incorrectly states that date. The

correct date is February 11, 2015. The Arbitrator also notes that two Commissioners affirmed the Decision of the Arbitrator while one Commissioner strongly dissented.
The second Commission decision, after Judge Cepero's remand, states a more detailed reasoning for its decision and persisted in affirming and adopting the Decision of the Arbitrator, declaring potions of Judge Cepero's Order to be "null and void"; as it states that the Commission is statutorily prohibited from ordering a second hearing on all issues before another Arbitrator and that the Circuit Court had exceeded the statutory authority, in its appellate capacity. It is agreed by both parties that there was no appeal perfected by the Petitioner, of this second Commission decision.

On or about February 27, 2015, Petitioner filed a Motion to Strike the Commission Decision and enforce the Circuit Court's first Order of September 24, 2013. Respondent responded with a 2-619 (a) (1) Motion to Dismiss stating the Court has no jurisdiction.

On or about March 25, 2015 the Circuit Court issues an Order for a Rule to Show Cause why the Commission should not be held in contempt. The commissioners were ordered to appear before the Circuit Court on April 8, 2015.

On April 3, 2015, the Commission enters a subsequent Order stating that pursuant to the Circuit Court Order of September 24, 2013, it is vacating its Decision and Opinion on Remand of January 14, 2015, (the correct date is February 11, 2015); and remanding the matter to Arbitrator Mason "for a new hearing, for a determination on all issues". This matter was never heard by Arbitrator Mason.

On April 8, 2015, a hearing was held before Judge Lopez Cepero wherein he did not hold the Commission in contempt.

On April 21, 2015 Respondent/Appellant filed a Summons for certification of a transcript of the April 3, 2015 decision and order; filing a Notice of Intent to File Review in Circuit Court.

On August 6, 2015, the parties appear before the Circuit Court on Petitioner's Motion seeking certification of two issues. The Court refused to certify either issue, stating that the Commission cannot ignore his remand instructions to have a new hearing by declaring that they have no statutory authority to do so and declaring that portion of his Order "null and void"; that they must follow the Circuit Court's Order.

On October 20, 2015, this matter came before a new judge, the Honorable Ponce de Leon, for status. Defendant subsequently filed a Motion to remand the case for a new hearing without the introduction of additional evidence. Petitioner requested and was granted leave to file a response to Defendant's motion. On November 17, 2015, the defendant filed its Reply Brief.

After various hearings and filings, this matter is now before Arbitrator Thompson-Smith, on Respondent's Motion to Dismiss the case because the Petitioner failed to perfect a review of the second decision rendered by the Commission on February 11, 2015; Petitioner having filed its Response and the Respondent having filed its Reply.

18IWCC0300

CONCLUSIONS OF LAW

This matter has been bandied about by both parties for over four years, while the Petitioner has languished without a resolution to his case; coming before this Arbitrator on or about July 2016. This Arbitrator relies on *Terry Noonan v. The Illinois Workers' Compensation Comm'n,* 2016 IL App (1st) 152300WC. As in *Noonan,* there must be comment on the path this claim has followed.

Pursuant to Noonan, "its frustration notwithstanding, the Commission cannot simply ignore the Circuit Court's Order" of September 24, 2013; which remanded the matter to the Commission, for a new hearing on all issues. "No matter how defective the circuit court's reasoning may have been, ... the Commission was charged with following the Court's order". *See, Northwestern University, v. Industrial Comm'n,* 409 Ill. 216, 219, 99 N.E.2d 18, 20 (1951).

The noted differences between Noonan and the instant case is that in Noonan, (1) the Petitioner filed a review from the second decision of the Commission; and (2) according to the Appellate Court, "the circuit court acted with no authority when ordering that the Commission's original decision should be upheld and its previous order was 'of no consequence';" further stating that "the court should not have addressed previous orders entered in the matter by either it or the Commission." The Appellate Court also stated that "a circuit court's jurisdiction to review a decision of the Commission is a 'special statutory power' and 'must be exercised within the limits prescribed by the relevant statute". *Illinois State Treasurer v. Workers' Compensation Comm'n,* 2013 IL App (1st) 120549WC".

Arguably, in this case, the circuit court did not exercise its special statutory power within the limits prescribed by statute however; apparently, it is not for the Commission to make that determination. The case having been remanded to the Commission by the circuit court for a new hearing on all issues and applying the law as stated in Noonan, the lower court has no discretion and must follow the circuit court's order; and have a new hearing on all issues.

Therefore: IT IS HEREBY ORDERED THAT:

Respondent's Motion to Dismiss is denied; and
This matter shall be set for a hearing on all issues before me.

I further sayeth naught.

__/L. Thompson-Smith_____
Arbitrator Lynette Thompson-Smith

Dated: December 5, 2016

This order is not interlocutory and therefore is appealable. Unless a review is filed within 30 days after receipt of this Order and a review perfected in accordance with the Act and Rules, then this Order shall be entered as the Order of the Commission.

DEC 5 - 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEELEY HOWARD,

Petitioner,

vs. NO: 11 WC 25806

STATE OF ILLINOIS
OFFICE OF THE OFFICIAL COURT REPORTER,

Respondent.

18IWCC0301

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner is a Court Reporter for the State of Illinois. At the time of trial, she had held this position for over thirty years. She operates a stenographic machine and laptop and works five days a week, 8:30a.m. to 4:30p.m., although she testified that she usually works past 4:30p.m.

2. Petitioner stated that she makes between fifteen hundred and eighteen hundred keystrokes daily on the stenograph machine, and additional keystrokes when creating the actual transcript.

18IWCC0301

3. On October 1, 2010 Petitioner was in a hearing when her thumbs locked up. She instinctively pulled them back into place and kept working. The locking occurred a few more times before she sought treatment with her primary care physician on February 11, 2011.

4. Petitioner was referred to an orthopedist, Dr. Coats, who diagnosed her with bilateral trigger thumb.

5. Petitioner received two injections in each thumb but got no relief. She also underwent therapy, which failed as well.

6. Petitioner returned to Dr. Coats, who recommended bilateral thumb surgery.

7. Petitioner underwent the surgeries on August 9, 2011. She was off work until September 6, 2011, when she was released to full duty with no restrictions.

8. Petitioner has worked in her normal capacity ever since with no issues.

9. Petitioner paid her physical therapy bill out of pocket, as well as $570.47 towards Dr. Coats' surgical bill.

10. Dr. Coats, although testifying that trigger finger itself was idiopathic, did opine that activities requiring repetitive motion of the hand would aggravate the condition.

The Commission affirms the Arbitrator's ruling with respect to accident, causal connection, medical expenses and temporary total disability. The Commission, however, views permanent partial disability slightly different than does the Arbitrator. Medical records provided fail to indicate a reason to award Petitioner any benefits for her hands bilaterally. Petitioner's testimony, medical care and surgical intervention all seem to be focused on her thumbs, with no relevant hand conditions of note. Accordingly, the Commission modifies the permanent partial disability award, vacating the bilateral hand awards while affirming the bilateral thumb awards.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $985.50 per week for a period of 5 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 $669.64 per week for a period of 30.4 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 20% loss of use of Petitioner's thumbs bilaterally.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $214.65 for medical expenses under §8(a) of the Act.

18IWCC0301

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent reimburse Petitioner for $4,188.47 for out-of-pocket expenses.

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. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving the credit.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $45,500.00. 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: MAY 15 2018
O:4/19/18
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWARD, KEELEY
Employee/Petitioner

Case# **11WC025806**

SOI OFFICE OF THE OFFICIAL COURT REPORTER
Employer/Respondent

18IWCC0301

On 7/25/2017, 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 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:

0190 LAW OFFICE OF PETER FERRACUTI
MORGAN KLEIN
110 E MAIN ST
OTTAWA, IL 61350

5946 ASSISTANT ATTORNEY GENERAL
HELEN LOZANO
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
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

JUL 25 2017

Ronald A. Rascia, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0301

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

Keeley Howard
Employee/Petitioner

v.

State of Illinois, Office of the Official Court Reporter
Employer/Respondent

Case # **11** WC **25806**

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 **06/27/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0301

FINDINGS

On February 11, 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.

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

In the year preceding the injury, Petitioner earned $77,911.00; the average weekly wage was $1,498.29.

On the date of accident, Petitioner was 51 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 paid $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits.

Respondent has paid $4,656.22 in benefits under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of $4,927.50 representing $985.50/week for a period of 5 weeks for temporary total disability.

Respondent shall pay Petitioner the sum of $669.64/week for a further period of 61.15 weeks, as provided in Section §8(e) of the Act, because the injuries sustained caused 7.5 % loss of use of the right hand and 7.5 % loss of use of the left hand and 20% loss of use of the right thumb and 20% loss of use of the left thumb.

Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $4,656.22 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall further pay the remaining $214.65 in unpaid medical bills to Dr. Robert Coats and reimburse Petitioner for $4,188.47 paid in out-of-pocket expenses.

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

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) temporary total disability; 5) medical bills; and 6) the nature and extent of Petitioner's injury. *See,* AX1.

Petitioner's testimony

Ms. Keeley Howard, (the "Petitioner"), has worked as a court reporter for the State of Illinois ("Respondent"), since 1986. The petitioner was 51 years old on February 11, 2011, with 25 years on the job. At the time of the accident, she was making $1,478.25 per week. Petitioner continues to work as a court reporter for the respondent.

Ms. Howard credibly testified and it is undisputed that she is assigned to various courthouses and court rooms in Cook County. She works operating a stenographic machine, 8:30 a.m. to 4:40 p.m., Monday through Friday, with occasional overtime on Saturdays.

Ms. Howard's duties are repetitive, typing testimony during trials, pleadings, hearings and motions. When there are breaks in a trial, she types and edits transcripts, switching from the stenograph machine to a laptop to produce transcripts that have been ordered. In addition to using her fingers, she uses her thumbs to make key strikes on both her stenograph machine and her laptop, making approximately 1500-1800 keystrokes on her machine per day.

Upon cross-examination, Petitioner testified that in addition to her typing duties she performs some limited ancillary functions such as making phone calls and filing transcripts, each of which may take up to 10 minutes of her day.

Per Petitioner's Exhibit 9, Ms. Howard works 6-8 hours per day using her hands for fine manipulation, which requires good finger dexterity. Petitioner's Exhibit 9 includes a document entitled "Supervisor's Report Of Injury Or Illness" in which Ms. Howard's supervisor, Jeanine Lamantia-Potter, reports that the duties of court reporter require "constant writing on steno machine to take down proceedings in courtroom setting", and Ms. Howard's injury was a result of "wear and tear on hands from constant use while performing job duties as reported by employee". Ms. Potter's report also states that the onset of the condition occurred while Ms. Howard was "typing on steno machine repeatedly".

On October 1, 2010, while in the courtroom operating her stenographic machine, both of Ms. Howard's thumbs locked. She testified that she "panicked" and had to physically pull her thumbs back into place then go back to typing.

Petitioner did not seek medical treatment until she saw her primary care physician on December 11, 2010 for a check-up complaining of thumb pain. Dr. Mitchell took x-rays which showed no abnormalities. (Petitioner Exhibit 3)

Dr. Mitchell referred Petitioner to Dr. Robert Coats, a board-certified orthopedic surgeon, and on February 11, 2011, Dr. Coats diagnosed Petitioner's condition as bilateral trigger thumb. (Petitioner's Exhibit 4).
Dr. Coats testified that he is a board-certified orthopedic specialist and after diagnosing Petitioner's condition of trigger thumbs, he initially planned conservative treatment, consisting of steroid injections and physical therapy.

Dr. Coats injected Petitioner's thumbs on her initial visit and followed-up with her on March 7, 2011; at which time she still had complaints of pain and stiffness in the left thumb; and triggering without pain on the right side so the doctor injected both thumps again.

According to Dr. Coats, if the triggering did not resolve with one or two injections, he would recommend pulley release surgery. He continued Petitioner's therapy and instructed her to return in another month.

Prior to undergoing surgery, Petitioner was provided thumb braces which interfered with her ability to feel the keys on her keyboard and she was forced to tape her thumbs to perform her job.

Upon return to Dr. Coats, it was determined that Petitioner was still experiencing catching in both thumbs and although her pain had improved, she did not have normal function in either thumb. Dr. Coats scheduled her for bilateral A1 pulley release surgery, which took place, without event, on August 9, 2011. Petitioner was off work from August 9, 2011 until she was released to return to work on September 7, 2011; during which time, she was not paid TTD and therefore used her sick leave.

Following surgery, Petitioner underwent physical therapy until she was released to return to work. After Petitioner returned to work, she was able to perform the essential functions of her job without pain or other issue; and has continued to work as a court reporter.

Dr. Coats testified to a reasonable degree of medical certainty that activity that requires repetitive motion of the hand would be aggravating to Petitioner's condition of trigger thumb. Respondent objected to Dr. Coats' opinion as to causation/aggravation on the basis for foundation, but Dr. Coats laid a sufficient foundation to render his opinion to a reasonable degree of medical certainty and the objections were not well founded and are overruled. Dr. Coats also testified that there can be metabolic causes to trigger thumb, but Petitioner did not suffer from those conditions. PX7.

Respondent offered the testimony of Dr. Michael Vender, a board-certified orthopedic surgeon. Dr. Vender was retained by Respondent to perform an independent medical examination ("IME") of Petitioner. Respondent attempted to elicit testimony from Dr. vender regarding causative factors of trigger finger, as well as a discussion of Petitioner's job duties based upon a job description that was

not provided to Petitioner, to which Petitioner objected based upon Respondent's failure to disclose such opinion.

820 ILCS 305/12 requires that opinion testimony be disclosed no later than 48 hours prior to the commencement of a hearing and pursuant to *Marks v. Acme Industries,* 02IIC0892(2002), hearing includes evidence depositions.

Respondent offered no rebuttal to the objection and did not dispute that there was a failure to disclose the entirety of Dr. Vender's opinions. The job description was not marked as an exhibit, nor was it attached to the transcript of Dr. Vender's testimony.

Dr. Vender's report was offered into evidence as Exhibit 2, and it does not disclose any opinions on alternative theories of causation, nor does it disclose that the doctor reviewed a job description. Likewise, there is no foundation for the job description to authenticate it and the failure to make proper disclosures violates section 12 of the Act as well as the court's ruling in *Ghere v. Industrial Comm'n*, 278 Ill. App. 3d 840 (1996), and as such the objections were sustained.

Dr. Vender did opine that Ms. Howard's work activities were not causally related to her condition, and the stresses placed upon Petitioner's thumbs would not be contributory or aggravating to her condition; but offered no opinion as to the reasonableness or necessity of the treatment Petitioner received.
Dr. Vender's testified that the cause of trigger finger is idiopathic and there are no known causes. He went on to state that repetitive use of the hands is good not bad and "the concept of someone not using their hands is what causes the disease." However, Dr. Vendor did not testify as to what types of stresses or what amount of force would be needed to cause or aggravate Petitioner's condition; and Commission precedent makes it clear that keyboarding activities such as those engaged in by Petitioner over an extended period, can cause or aggravate the condition of trigger finger. *See Womack v. Illinois Department of Corrections,*16 IWCC 361(2016), and *Myers v. State of Illinois* 15 IWCC 418 (2015); both of which support and award for Petitioner under the facts presented here.

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision as to C. DID AN ACCIDENT WHICH AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT. D. WHAT WAS THE DATE OF ACCIDENT and E. WAS NOTICE OF THE ACCIDENT PROVIDED, the Arbitrator finds the following:
Under the Illinois Workers' Compensation Act (the "Act"), compensation may be awarded for a claimant's condition of ill-being even though the conditions of his or her employment do not constitute the sole, or even the principal, cause of injury. *Lasley Construction Co. v. Industrial*

Comm'n, 274 Ill. App.3d 890, 893 (1995), *Teska v. Industrial Comm'n*, 266 Ill. App.3d 740, 742 (1994).

Additionally, an injury is considered accidental even though it develops gradually over a period of time, as a result of a repetitive trauma, without requiring complete dysfunction, if it is caused by the performance of claimant's job. *Cassens Transport Co. v. Industrial Comm'n*, 262 Ill. App.3d 324, 330 (1994).

Although Dr. Vendor's attempt to offer an opinion as to other causes of trigger finger was not allowed, even if that testimony had been properly disclosed it would not affect the decision since a nonemployment related factor which is a contributing cause with the compensable injury in an ensuing injury does not break the causal connection between the employment and claimant's condition of ill-being. Teska, 266 Ill. App.3d at 742. *See also, International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4 (1979).

It is unrebutted that Petitioner spent 6-8 hours a work-day engaged in a job that required fine manipulation of her hands and thumbs; and that her condition developed after 25 years of repetitive use of her hand sand thumbs. No evidence was offered as to any cause other than as testified to by Petitioner and she has proven, by a preponderance of the evidence that her injuries were work related.

On the issue of notice, the date of accident or manifestation can be determined in many ways. Petitioner was not diagnosed with trigger finger until she was referred to and examined by Dr. Coats on February 11, 2011. Per Respondent's Exhibit 1, Petitioner gave notice to her supervisor on February 14, 2011. The Arbitrator notes that February 14 was a Monday and the first work day after Petitioner's diagnosis, and as such Petitioner gave notice within 3 days of when she became aware of her diagnosed condition and its relationship to her work. Respondent offered no rebuttal testimony and the Arbitrator finds that the date of manifestation is February 11, 2011.

Respondent argues that on January 8, 2011 Petitioner was diagnosed with tendonitis by her primary care doctor. While tendonitis is a generalized term for inflammation of a tendon, and the exact diagnosis was not made until Petitioner was examined by Dr. Coats, both January 8 and February 14 are within the 45-day period for giving notice and the Arbitrator finds that notice was timely and proper.

In support of the Arbitrator's Decision as to F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The Arbitrator finds that the petitioner's bilateral trigger thumb condition is causally related to the accident. In reaching this opinion the Arbitrator relies on the opinion of Dr. Coats as discussed above, whose testimony is more credible than that of Dr. Vender. At a minimum Petitioner's daily work duties aggravated her underlying trigger thumb condition and under Illinois law, the accident need only be a cause of a condition of ill-being, and need not be the primary or prevailing factor. Taking the totality of the evidence, the Arbitrator believes the greater weight of the evidence supports a causal connection in this case.

In support of the Arbitrator's Decision as to J; WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? WHAT AMOUNT OF REASONABLE, RELATED, AND NECESSARY MEDICAL EXPENSES SHOULD BE AWARDED, AND N. WHAT CREDITS ARE DUE RESPONDENT, the Arbitrator finds the following:

Petitioner's Exhibit #1 is a compilation of medical expenses related to the Petitioner's trigger thumb and subsequent surgery performed by Dr. Coats. Dr. Coats testified that he unsuccessfully attempted conservative treatment and only after therapy and steroid injections failed did he perform surgery. In addition, the surgery was uneventful and successful in relieving Petitioner's symptoms.

Respondent offered no testimony to contradict Dr. Coats regarding his approach to treatment and the Arbitrator finds that the medical services rendered were reasonable and necessary. Thus, the Arbitrator finds that Petitioner shall be reimbursed $4,188.47 for her out of pocket medical expenses, plus $214.65 for the balance due Dr. Coats. This award is subject to Sections 8 and 8.2 of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit of $4,656.22, as provided in Section 8(j) of the Act.

In support of the Arbitrator's Decision as to K; WHAT TEMPORARY BENEFITS ARE IN DISPUTE; the Arbitrator finds the following:

Respondent's objection to temporary disability payments is based upon liability only. The Arbitrator having determined liability, hereby awards Petitioner $4,927.50 representing $985.50/week for a period of 5 weeks for TTD.

In support of the Arbitrator's Decision as to L; THE NATURE AND EXTENT OF THE DISABILITY, the Arbitrator finds the following:

Petitioner was diagnosed with bilateral trigger thumb and underwent surgery on both thumbs to correct her condition. The petitioner credibly testified at hearing that her condition was resolved through surgery and she has returned to normal activities.

The Arbitrator has taken into consideration the five factors found in Section 8.1b of the Act to determine the permanent partial disability of the Petitioner in this case. Those factors include: (1) the reported level of impairment pursuant to subsection (a); (2) the occupation of the injured worker; (3) the age of the employee at the time of the injury; (4) the employee's future earning capacity; and (5) evidence of disability corroborated by the treating medical records.

(1) The reported level of impairment - Neither party submitted an AMA impairment rating thus, the Arbitrator does not give any consideration to this factor.

(2) The occupation of the injured worker – The Arbitrator notes that Petitioner was employed as a court reporter for Respondent prior to the accident date and continues in that occupation. This occupation is repetitive in nature therefore the Arbitrator gives some weight to this factor.

(3) The age of the employee at the time of the injury – The Petitioner was 51 years old on the date of accident associated with her injuries. The Arbitrator considers the petitioner to be on the down-hill side of her career and therefore gives some weight to this factor.

(4) The employee's future earning capacity – There was no evidence in the record that Petitioner's future earning capacity was affected by these injuries.

(5) Evidence of disability corroborated by the treating medical records – The medical treatment records are consistent with Petitioner's testimony that she underwent surgical intervention for the bilateral trigger thumb. Petitioner also testified to the discomfort and effect of the trigger thumb and that prior to surgery she was required to wear braces which interfered with her ability to type, and she taped her thumbs in order to perform her duties. Petitioner's condition also impacted on her quality of daily activities. The Arbitrator gives some weight to this factor.

Based upon the greater weight of the evidence and the consideration of the five factors as indicated above, the Arbitrator finds that the Petitioner is entitled to an award of permanent partial disability benefits of $669.64 for 61.15 weeks because the injuries sustained caused 7.5 % loss of use of the right hand and 7.5 % loss of use of the left hand and 20% loss of use of the right thumb and 20% loss of use of the left thumb.

18IWCC0301

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11WC25806
SIGNATURE PAGE

Signature of Arbitrator

July 25, 2017
Date of Decision

JUL 25 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

Anthony G. Bova,
Petitioner,

vs. No: 14 WC 14491

18IWCC0302

Safelite Auto Glass,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2017, is hereby affirmed and adopted.

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

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

18IWCC0302

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: MAY 16 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-05/09/18
jdl/wj
68

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

BOVA, ANTHONEY G
Employee/Petitioner

Case# **14WC014491**

SAFELITE AUTO GLASS
Employer/Respondent

18IWCC0302

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:

1497 MORICI FIGLIOLI & ASSOC
ROBERT H BUTZOW
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
ERIN K FIORE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

18IWCC0302

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)

ANTHONY G. BOVA
Employee/Petitioner

v.

SAFELITE AUTO GLASS
Employer/Respondent

Case # **14** WC **14491**

Consolidated cases: **N/A**

18IWCC0302

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, IL**, on **September 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **3/25/14**, 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 **$40,040.00**; the average weekly wage was **$770.00**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$N/A** for TTD, **$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

The Respondent shall authorize and pay for the prospective medical treatment, including but not limited to the surgical treatment recommended by the Petitioner's current treating physician, Dr. James M. Hill/Illinois Bone & Joint Institute, 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.

Deborah L. Simpson

Signature of Arbitrator

January 17, 2017
Date

ICArbDec19(b)

FEB 14 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony G. Bova,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 14491**
	)	
Safelite Auto Glass,	)	
	)	
Respondent.	)	**18IWCC0302**
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on March 25, 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. They agree that in the year preceding the injuries, the Petitioner earned $40,040.00, and that his average weekly wage was $770.00.

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) Was timely notice of the accident given to Respondent; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is the respondent liable for any unpaid medical bills; and (5) Is Petitioner entitled to prospective medical care.

STATEMENT OF FACTS

Petitioner testified that he was an employee of Safelite for five years at the time of his injury. Petitioner testified that his job duties were for installation of auto glass, which included lifting 40 to 50 lbs., or more if a semi was involved, removing the glass, gluing it back in and climbing ladders or up and down trucks to get to the windshield.

Petitioner testified that he had no problems before the accident with his job duties. However, he did admit to prior injuries in 2002 and 2004. The 2002 injury was a workers' compensation injury to the left knee where he had an ACL repair. The 2004 injury was a workers' compensation injury to the right knee with an ACL repair. Petitioner testified that he had been released from Dr. James Hill after that treatment and had sought no medical treatment for the five years prior to the accident. He further testified that he had no problems with activities of daily living or work prior to the accident.

Respondent submitted the records of Illinois Bone and Joint Institute/Dr. James Hill as its Exhibit 3. These records indicate an injury in May or June of 2001 at work to the left knee.

(RX3 at 35). On November 13, 2002, Petitioner underwent a left knee arthroscopy with partial lateral meniscectomy and ACL reconstruction. (Id. at 53). On January 20, 2004, Petitioner was released. He was still reporting intermittent persistent pain in the anterior region of the knee, especially with kneeling as well as occasional medial pain with prolonged ambulation. (Id. at 25).

Petitioner presented for a new complaint to the right knee on January 18, 2005. (RX3 at 24). At that time he stated his left knee had essentially completely resolved but that he sustained another work related injury to the right knee when he jumped off a truck. Id. Petitioner eventually underwent a right knee arthroscopy with partial medial meniscectomy on April 13, 2005. (Id. at 42). Petitioner was discharged from care and released to full duty work on May 10, 2005. (Id. at 20). At the time of the discharge, Dr. Hill's note references that Petitioner reported some discomfort in his knees, especially when ascending and descending stairs. Id.

Petitioner testified that on March 25, 2014, he was installing the front windshield on a semi, where he had climbed up the tire, the engine block, etc., onto the semi. After installing the windshield, he slipped and landed on the ground with his feet. He testified his legs buckled and then he fell sideways to the ground. He could not stand for a second because he felt immediate pain. He did finish the job. Petitioner went back to the office and told his supervisor, Angel about the accident. He testified that Angel suggested he go to Concentra.

Petitioner first presented for treatment on March 28, 2014, to Concentra. (PX1). He reported pain in both knees and pain when climbing up truck or stairs. Id. He received a prescription for physical therapy. Id. Petitioner testified that he did leg stretches, the stair climber and used the sponge ball for therapy but it did not help and actually worsened his symptoms. Petitioner submitted Exhibit 1, the medical records of Concentra Immediate Care, which document therapy visits through May 2, 2014. At that visit, Petitioner was referred to an orthopedic specialist and he testified he preferred to follow up with his personal specialist, Dr. Hill. Id.

Petitioner testified that he decided to go see Dr. Hill. Petitioner testified that he first saw Dr. Hill on July 1, 2014. He testified that he had the same pain in his knees at that visit as at the time of the fall. X-rays were taken.

Petitioner obtained a narrative opinion from Dr. Hill which is dated November 11, 2014. As to causation the doctor stated:

> It is my medical opinion to a reasonable degree of medical certainty that Mr. Bova's bilateral knee pain was specifically aggravated by his stated work related injury on 3/25/14. The patient clearly had a pre-existing predisposition to medial compartment osteoarthritis in both knees based on his previous diagnostic studies. However, he states that he has been working with his current company over a prolonged period of time. His prolonged ambulatory activities as well as kneeling and squatting required in his work related duties certainly have predisposed him to acceleration of these degenerative changes. I believe his fall from the truck hood was the final exacerbation of his symptoms. Although his fall certainly did not cause his degenerative changes, it certainly was an exacerbation of an underlying condition.

(PX3).

Petitioner underwent a Section 12 examination by Dr. Nirav Shah on February 18, 2015, at the request of the employer. Dr. Shah took Petitioner's personal medical history and reviewed a few medical records. Petitioner reported his prior knee complaints and treatment with Dr. Hill. On physical examination, Petitioner pointed to all areas of the knee as painful. He indicated more pain with activities, squatting, kneeling and bending. He stated sometimes the right knee feels like it gives out and that it is worse compared to the left. The doctor noted no signs of overreaction, distraction tests were negative and Waddell signs were negative. The doctor's diagnosis is bilateral painful knee osteoarthritis, aggravated by the work injury. As to causation, the doctor states: there is a causal relationship, but notes the pre-existing osteoarthritis that was not caused by the injury but was only caused to be made painful by the injury. He states that treatment has been reasonable to date. As to future treatment, viscosupplementation could be necessary. He opined further that the injury did not aggravate his injury to the point where he would need a knee replacement. RX1.

Petitioner testified that Dr. Hill recommended he undergo Cortisone shots. He testified that he underwent two shots and they did not help. He testified the shots did not help more than a day.

Petitioner obtained a second narrative opinion from Dr. Hill dated August 13, 2015. Dr. Hill reviewed the IME report of Dr. Shah and provided his response. Dr. Hill points out that Dr. Shah was unaware of the amount of treatment that Dr. Hill had rendered over the past decade, including conservative treatment. He states:

> Therefore, unbeknownst to Dr. Shah, the patient has received a full course of conservative management without receiving any long term benefit. It is therefore my opinion based on a reasonable degree of medical and surgical certainty, that the patient has sustained a permanent aggravation of his pre-existing underlying knee osteoarthritis related to this stated work related injury in March of 2014.

(PX4).

Respondent obtained an addendum opinion from Dr. Shah dated August 10, 2016. Petitioner's diagnosis is listed as bilateral knee osteoarthritis. Dr. Shah's interpretation of the MRIs from January 2015, is osteoarthritis, evidence of prior meniscectomies and chronic ACL insufficiency. As to causal relation, the doctor states:

> His current complaints are related to osteoarthritis in bilateral knees. Osteoarthritis is a degenerative condition not caused by the current work accident. The current work accident may have exacerbated his symptoms. Symptoms of arthritis appear to be present prior to this most recent injury in 2014 as shown by Dr. Hill's clinical notes in 2002, noting that the patient had symptoms consistent with arthritis at that time including x-ray findings showing joint space loss, subjective findings of pain and stiffness with ascending and descending stairs as

recent as 2005. Additionally, arthroscopy reports from 2002 report chondromalacia grade III in the medial compartment consistent with a history of arthritis. Also present were grade IV chondromalacia in the patellofemoral joint at the time of arthroscopy.

As to prospective medical care, the doctor states the Petitioner needs knee replacements bilaterally to address pain from osteoarthritis but that the osteoarthritis was not caused by the work related accident. He further states that Petitioner is at MMI as it relates to the most recent work injury but does require bilateral knee replacements due to the arthritis. RX2.

Petitioner testified that he has been working this whole time but that he does not use ladders and he does not lift greater than 50 lbs. He states that he no longer works with Safelite and that he has been at his current job, doing the same thing, for three years. This Arbitrator notes that Petitioner's timing was inaccurate and that the parties later stipulated that Petitioner was terminated on April 10, 2014.

Petitioner testified that he has never subsequently injured his left or right knees. He states that at this time he has difficulty climbing stairs, ladders and that it hurts to walk home by the end of the day. Petitioner testified that he is okay when he is sitting but that he has problems standing and he can only walk half a suburban block before he has problems. He testified that he still does his job but he does it slower. He testified that as to his personal life, he cannot golf anymore. Petitioner testified that he golfed two times per month prior to the accident.

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)

Employment need only remain a cause, not the sole cause or even the principal cause, of a claimant's condition. *Rotberg v. Industrial Comm'n*, 361 Ill.App.3d 673, 682, 297 Ill.Dec. 568, 838 N.E.2d 55 (2005).

In Support Of The Arbitrator's Decision As It Relates To Whether An Accident Occurred That Arose Out Of And In the Course of Petitioner's Employment With The Respondent, The Arbitrator Finds The Following:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner suffered an accident which arose out of and in the course of his employment with Respondent as Petitioner's accident was performed while doing his regular job duties, during his regular shift. Petitioner met his burden of proof when he testified that he was changing a windshield on a semi, and that he slipped as he was descending and jammed both of his knees.

In Support Of The Arbitrator's Decision As It Relates To Whether An Petitioner Provided Timely Notice Of An Accident, The Arbitrator Finds The Following:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner provided notice of the accident on the same date it occurred, which satisfies the requirements of Section 6 of the Illinois Workers' Compensation Act. Petitioner testified that he notified his supervisor, Angel, and she referred him to Concentra for medical treatment. Petitioner testified that he first sought treatment for the injury at Concentra and the medical records support this testimony. Respondent provided no contradictory evidence.

In Support Of The Arbitrator's Decision As It Relates To Whether Petitioner's Current Condition Of Ill Being Is Causally Related To The Injury, The Arbitrator Finds The Following:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

This Arbitrator finds that Petitioner's current condition of ill-being, and the need for bilateral total knee replacements, is causally related to the work accident. In making this finding, this Arbitrator relies on the medical records, Petitioner's testimony, and the opinions of the treating doctor, Dr. Hill as well as portions of the opinions of Dr. Shah.

Based on the evidence produced at trial, the Arbitrator finds that the injury of March 25, 2014 was a causative factor in Petitioner's resulting condition of ill-being relating to his right and left knees. The Arbitrator finds that the Petitioner was asymptomatic and had not had problems with his right and left knees that precluded him from performing any part of his job duties prior to the injury. Petitioner credibly testified that he continued to experience pain in his right and left knees since the injury.

The Arbitrator relies on the opinion of treating physician Dr. Hill to the extent that the accident caused acceleration or permanent aggravation of the Petitioner's pre-existing osteoarthritis, necessitating treatment for the right and left knees and ultimately resulting in a recommendation for surgery. There is no disagreement that the Petitioner had prior surgeries to his right and left knees by Dr. Hill approximately ten (10) years prior to the March 25, 2014 accident and, as a result of those surgeries, had developed osteoarthritis. However, the Petitioner testified that he was asymptomatic while working for the Respondent without difficulty until his injury on March 25, 2105. This testimony stands un-rebutted, and no medical evidence was submitted showing that the Petitioner suffered any other injuries to his knees until his first date of treatment with Concentra immediate Care on March 28, 2014, or that the Petitioner was under the care of a licensed physician at any time prior to the March 25, 2104 injury. While his pre-existing condition arthritic condition may or could have warranted total knee replacement surgery, at some indeterminable point in the future, the Petitioner had no imminent medical directives for the same. It was not until after the March 25, 2014 accident, that the Petitioner sought medical treatment and received recommendations for a total knee replacement surgery for his ongoing condition. The issue is whether the accident at work on March 25, 2014 caused the need for the knee replacement surgery, as it permanently aggravated or accelerated the pre-existing arthritic condition, or if the work accident only caused a temporary exacerbation of Petitioner's pre-existing condition, which eventually returned to the pre-accident condition. The treating physician, Dr. James M. Hill and the IME physician Dr. Nirav Shah give differing medical opinions as to this causation issue. Dr. Hill opined that although the Petitioner had a pre-existing condition, the Petitioner did not have a pre-existing problem with his knees until after the March 25, 2014 accident. Dr. Hill opined that the pre-existing osteoarthritic condition was worsened and permanently aggravated by the work accident, which hastened the need for the total knee replacement surgery (PX2, PX3, & PX4). Dr. Shah opined that the accident of March 25, 2014 only caused a temporary exacerbation of Petitioner's pre-existing arthritic knee condition. Dr. Shah has ruled out any relationship between the Petitioner's work accident of March 25, 2014, and the surgeries prescribed by Dr. Hill, and believes that it was not a contributing factor in the Petitioner's diagnosed medical condition which is due solely to the Petitioner's degenerative condition in his right and left knees (RX1, RX2). The Arbitrator gives greater weight to the opinions of Dr. Hill, as it relates to medical causation, as he had performed previous knee surgeries approximately ten (10) years prior and, therefore, more familiar with the Petitioner's condition as it relates to the Petitioner's knees, and the effect of the type of injury the Petitioner sustained on March 25, 2014 on the preexisting osteoarthritis condition which had been diagnosed subsequent to that workplace injury.

The Arbitrator finds that Dr. Shah's causation opinion is in conflict with the applicable case law that the Petitioner's work injury can be a contributing factor to the present condition of ill being; and that the Petitioner has shown through a preponderance of evidence, that some act of his employment was a causative factor with regard to his injury. It is axiomatic that employers take their employees as they find them, and worker's compensation benefits should not be limited to only those individuals who have no underlying health condition. It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the pre-existing disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the pre-existing condition. Sisbro, Inc. v. Industrial Commission, 207 Ill. 2d 193, 797 N.E.2d

665, (2003). Thus, even though an employee has a pre-existing condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. Caterpillar Tractor Co. v. Industrial Commission, 92 Ill.2d 30, 440 N.E.2d 861 (1982). The work 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 Commission, 37 Ill.2d 12, 227 N.E.2d 65 (1967). Additionally, medical evidence is not an essential ingredient to support a conclusion as to whether a workplace accident caused the Petitioner's resulting disability. A chain of events which demonstrates a previous condition of good heath, and accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury, International Harvester v. Industrial Commission, 93 Ill. 2d 59, 442 N.E 2d 908 (1982). This "chain of events" theory of causation is not limited to an employee who did not have a preexisting condition involving the same area of the body for which he claims injury, but can also be used to demonstrate the aggravation of a preexisting condition, Price v. Industrial Commission, 278 Ill. App. 3d 848, 633N.E. 2d 1057 (1996).

Based upon review of all the evidence produced at arbitration, including credible testimony of the Petitioner, the medical records admitted into evidence, and the opinions of Dr. James M. Hill, the Petitioner's treating physician, the Arbitrator finds that the Petitioner sustained permanent aggravation and exacerbation of pain as a result of the work injury of March 25, 2014, as his condition became symptomatic and Petitioner never returned to the pain free condition that he experienced prior to the March 25, 2014 injury and that a causal relationship exists between Petitioner's current condition of ill-being and the accident on March 25, 2014.

In Support Of The Arbitrator's Decision As It Relates To Whether Medical Services Were Reasonable And Necessary, The Arbitrator Finds The Following:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

This Arbitrator finds that Petitioner's medical treatment has been reasonable and necessary.

In Support Of The Arbitrator's Decision As It Relates To Whether Petitioner Is Entitled To Any Prospective Care, The Arbitrator Finds The Following:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that the work injury was a causative factor in bringing about the Petitioner's current right and left knee conditions and the ensuing need for treatment. The Petitioner is entitled to prospective medical care as prescribed by his treating orthopedic surgeon, Dr. James M. Hill. The Petitioner testified that despite conservative treatment, he continues to have significant continuous pain in his right and left knees. The Petitioner testified in detail with

respect to his continued symptoms, his inability to perform various activities due to his knee pain. The Arbitrator finds the Petitioner's un-rebutted testimony with respect to his current condition of ill-being to be credible and consistent with the medical records submitted at arbitration. The Arbitrator notes that the Petitioner has remained under the care of Dr. Hill, in an attempt to alleviate his ongoing pain symptoms.

Dr. Hill has documented his opinion in his treatment notes and narrative reports that due to the workplace injury the Petitioner sustained an injury to his right and left knees and that the Petitioner is a candidate for surgery due to his persistent and ongoing symptoms of right and left knee pain (PX2, PX3 & PX4). The Arbitrator finds while the doctors disagree with the causal connection between the need for surgical intervention and the accidental injury, both the Petitioner's treating physician, Dr. Hill, and the Respondent's examining physician, Dr. Shah, have opined that Petitioner needs prospective medical care, due to the current condition of the Petitioner's right and left knees. The Arbitrator notes that the Petitioner's last evaluation with Dr. Hill was on Jun 16, 2015, and at the time, Dr. Hill continued to recommend surgery in an attempt to relieve Petitioner's right and left knee symptoms (PX2). Given the credible and un-rebutted testimony of the Petitioner, a review of the medical records, containing the opinions of the treating orthopedic surgeon, Dr. James M. Hill, that a right and left total knee arthroplasty is the only appropriate treatment option for the Petitioner's ongoing condition; and the Arbitrator finds that these recommendations are both reasonable and necessary.

Therefore, based upon the above, and the record taken as a whole the Arbitrator finds that the Petitioner is entitled to prospective medical care and treatment in the form of a right and left knee arthroplasty surgery as prescribed by Dr. Hill, and that the Respondent is hereby liable for the reasonable and necessary costs associated therewith pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act.

ORDER OF THE ARBITRATOR

The Respondent shall authorize and pay for the prospective medical treatment, including but not limited to the surgical treatment recommended by the Petitioner's current treating physician, Dr. James M. Hill/Illinois Bone & Joint Institute, as provided in Section 8(a) of the Act.

Deborah L. Simpson

Signature of Arbitrator

January 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tarik Sheikh,
Petitioner,

vs. No: 14 WC 38157

Envoy,
Respondent.

18IWCC0303

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 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.

18IWCC0303

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: MAY 16 2018

Joshua D. Luskin

o-05/09/18
jdl/wj
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

SHEIKH, TARIQ
Employee/Petitioner

Case# **14WC038157**

ENVOY
Employer/Respondent

18IWCC0303

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:

3098 MICHAEL NICHOLSON
7111 W HIGGINS RD
CHICAGO, IL 60656

1109 GRANT SCHREIBER & STORM
DANIEL L GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tariq Sheikh
Employee/Petitioner

v.

Envoy
Employer/Respondent

Case # 14 WC 38157

Consolidated cases: _____

18IWCC0303

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 **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] 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, **7/2/14**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**55,787.52**; the average weekly wage was $**1,072.84**.

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

ORDER

The arbitrator denies compensation for medical bills and prospective medical care.

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 20, 2017
Date

ICArbDec19(b)

FEB 21 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tariq Shiekh	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 14 WC 38157
	)	
Envoy	)	
	)	18IWCC0303
Respondent.	)	

FINDINGS OF FACT

Petitioner's Testimony:

Petitioner, an aircraft maintenance mechanic for respondent, testified that on July 2, 2014, he was pushing a cart filled with 3 big bottles of nitrogen and 1 big bottle of oxygen when he slipped and fell and landed on his left knee. The ground was a little wet due to the rain. He further testified that he was alone at the time he fell; his co-worker was inside the plane.

After he fell, he tried to get up and then got up. He told his co-worker inside the plane what had happened and his co-worker talked with the supervisor. Petitioner testified that he "was getting an accident report that [he] had fallen at the plane." He testified that he felt very bad pain after the fall and "can't move at least a half hour and had swelling, and [he] still has swelling on [his] knee." He has walked with a limp following this slip and fall.

Petitioner then testified: "After the next day when I go to my family doctor, and he referred me to Dr. Levi." He went to see Dr. Zaki, and then Dr. Zaki referred him to Dr. Levi at Ortho Rehab. He told Dr. Levi everything that had happened. Dr. Levi took x-rays of the knee, gave him a shot in the knee and told petitioner to take off work. Petitioner did not take off work because if he went on a leave of absence, his wages would be cut down.

Dr. Levi kept him off work 3 to 4 weeks at least, and then he wanted to perform surgery on petitioner. The shot that Dr. Levi gave petitioner helped him "[f]or the time being only." He had maybe 2-3 sessions of physical therapy, but no more shots. Dr. Levi

said petitioner needed surgery, and suggested that, otherwise, "we cannot do nothing." Petitioner would take Aleve twice a day every day for the pain relief.

Petitioner further testified that when Dr. Levi examined him, he told him that he needs a knee replacement for his left knee, that he will then be off work and will get physical therapy.

Petitioner testified that he saw Dr. Zaki Siddiqui for both knees 9 months before the accident; he took x-rays and gave petitioner steroid shots in both knees. He said that the shots he received would help a little bit for about 4 or 5 weeks, and then he would have a little bit of pain. Petitioner then testified that after the shots, his knees would be good for 2 or 3 weeks, and then for 2 or 3 months, his knees would not be good.

Petitioner testified that he did not recall the last time he saw Dr. Siddiqui before the accident. He further testified that before the accident, he was able to walk without limping. Petitioner testified that he has unpaid medical bills from Dr. Levi in the amounts of $461.00 and $275.00.

Then, petitioner testified to the following:

Q: Before the accident happened, how did you feel with respect to your legs? Did you continue to have problems before the accident after you were done treating?

A: No, it was good. After treatment, it was good.

Q: The last time you saw Dr. Siddiqui before the accident, were you able - - everything was okay?

A: Yes.

Q: You're only claiming compensation for your left knee, right?

A: Yes. (Tr. 20)

Petitioner testified that he told Dr. Levi that he did not want any "drowsy medicines." He testified that he did not sustain any other accident to his left knee either before or after July 2, 2014. He did not sustain any accident to the knee at home.

Currently, petitioner finds it difficult to work and finds that he "cannot stand right away." He notices that his knee is swollen up and that "it is still swollen every time." Dr. Levi has recommended a brace for his knee. Petitioner uses the brace all the time. Sometimes the brace gives him relief from the pain, and sometimes the brace gives him

more pain. He wears the brace at work, but whenever he feels pain, he takes the brace off. He never had a limp before the accident. Petitioner has not asked respondent for any work accommodations. Petitioner has earned the same wages since the accident.

On cross-examination, petitioner testified that before the July 2, 2014 accident, he was having problems with his left knee for several years. He testified that he sought treatment with his family doctor, Dr. Zaki, but did not recall the last time he treated with this doctor before the accident.

Petitioner testified that x-rays of both knees were taken on March 27, 2014 because he was told that he had arthritis in both of his knees. He testified that he received an injection in March 2014. Petitioner testified that the pain medication he has taken since the accident, Aleve, is the same pain medication he took before the accident. He testified that after Dr. Zaki injected his knee in March, he told petitioner to follow up in a few months to discuss his knee. Dr. Zaki never discussed a total knee replacement with petitioner.

After his fall, petitioner testified, he had a second round of x-rays taken. Dr. Levi recommended the total knee replacement. Petitioner further testified that both before and after July 2, 2014, he did not lose any time from work due to the condition of his left knee.

Petitioner testified that he has not personally provided Dr. Levi with copies of his medical records or his x-rays from before the accident. Petitioner filled out forms with Dr. Levi and then had x-rays taken. Petitioner is currently performing the same job he did before the accident.

In October 2015, petitioner saw Dr. Jacobs for an independent medical examination.

On redirect examination, petitioner testified that Dr. Siddiqui treated petitioner before the accident for both knees. After the accident, he first went to see Dr. Siddiqui. Dr. Siddiqui then referred him to Dr. Levi.

He went to see Dr. Jacobs on October 5th. He had never seen Dr. Jacobs before that time. He spent maybe half an hour with Dr. Jacobs in the examination room. Petitioner answered all of Dr. Jacobs' questions.

Medical Records and Reports:

The medical records show that on March 26, 2014, petitioner saw Dr. Siddiqui for a routine health check, and had no new complaints. Dr. Siddiqui recorded that petitioner complained of joint pain, on and off, and that he was taking Aleve as needed. Dr. Siddiqui diagnosed Tariq Sheikh with arthritis, and referred him to Swedish Covenant Hospital for x-rays of his bilateral knees. (Rx.2)

On March 27, 2014, x-rays of petitioner's knees were taken at Swedish Covenant Hospital. The x-ray report states a clinical indication of bilateral knee pain.

With regard to these x-rays, which captured 6 views, Howard Pinchcofsky, M.D., made the following findings and offered the following impression:

"Findings:

Right knee: There is no acute fracture or dislocation. Bone mineralization is normal. There is tricompartmental osteophytic spurring and moderate to severe patella-femoral joint space narrowing. A small suprapatellar effusion is present. The inter-condylar eminence is prominent, and there is faint chondrocalcinosis in the medial and lateral menisci.

Left knee: There is no acute fracture or dislocation. Bone mineralization is normal. There is moderate medial and patellofemoral compartment joint space narrowing, tricompartmental osteophytic spurring, and prominence of the intercondylar eminence. Chondrocalcinosis is noted in the menisci. There is a small supra-patellar effusion.

Impression: Bilateral CPPD arthropathy with small, bilateral suprapatellar effusions." (Rx.2)

Petitioner followed up with Dr. Siddiqui on April 2, 2014. Dr. Siddiqui noted that petitioner had pain in his knees for 1 month, on and off. Upon examining petitioner, Dr. Siddiqui found that petitioner has "FROM left and FROM right with slight pain, no deformities, bilateral knee slight swelling over platella (sic) area." Dr. Siddiqui's diagnoses included "Arthritis." Among other things, he recommended weight loss and a knee brace.

He advised petitioner to follow up in two weeks for joint pain, and wrote that if it is not better, he would consider a joint injection. (Rx.2)

On April 20, 2014, petitioner followed up with Dr. Siddiqui. Upon examining petitioner's extremities, Dr. Siddiqui found a full range of motion, no deformities, slight swelling at patellar area, and no erythema. Dr. Siddiqui diagnosed him with bilateral knee pain and noted that the x-rays show arthritic changes. Dr. Siddiqui wrote that petitioner has a bad knee joint due to wear and tear, and that he has used all his medication for pain without complete relief. Dr. Siddiqui injected petitioner's knee with 1 ml. of Kenalog (40 mg.) and 1 ml. of 2% Lidocaine, but did not indicate which knee. Dr. Siddiqui also wrote: "patient walked after injection expressed no joint pain and is happy." He prescribed pain medication and instructed petitioner to follow up in 3 months for joint injection if it helped. (Rx.2)

The first documented history in evidence of petitioner's July 2, 2014 slip and fall injury appears in the July 10, 2014 chart notes of petitioner's primary care physician, Zaki Siddiqui, M.D. Such notes state, in pertinent part, the following:

Chief complaint

***

Reason: pt. slipped 1 week ago and hurt his left knee and complains he still has swelling and pain.

***

Medications: Aleve

***

Subjective

Tariq was pushing the cart on the TARMAC. It was wet and slippery and he slipped and hurt his left knee a week ago. Still pain full (sic) and has slight swelling and hurts when bare (sic) weight in the left leg.

***

As patient has h/o knee pain due to arthritis

Objective

***

Extremities: FROM, no deformities, left knee slight swelling at patellar and medial area, no erythema. No hematoma

***

Assessment

Diagnoses attached to this encounter.

(719.46) Pain in left knee

Plan

AG/ST/HO

KNEE SUPPORT

X-RAY LEFT KNEE JOINT

Diclofenac sodium 75 mg po qd

f/u in 2 weeks for evaluation" (Rx.2)

On July 12, 2014, x-rays of petitioner's left knee were taken at Swedish Covenant Hospital. The x-ray report states the "reason for exam": left knee pain.

With regard to such x-rays, which captured 4 views, Matthew Pearce, M.D., made the following findings and offered the following impression:

"FINDINGS:

There is severe tricompartmental osteoarthritis with joint space narrowing, subchondral sclerosis, and osteophytosis. No fracture or dislocation is seen. There is no periosteal reaction or bone destruction.

IMPRESSION: Severe tricompartmental osteoarthritis." (Rx.2)

On November 21, 2014, orthopedic surgeon Gabriel S. Levi, M.D., first examined petitioner. He authored a report and carbon copied Zaki Siddiqui, M.D. Dr. Levi recorded, in pertinent part, the following:

Chief Complaint:

Left knee pain

History of Present Illness:

The patient presents today for an initial evaluation of left knee pain.

The pain began on 7/2/2014.

The patient was injured while at work.

The patient however states his claim was denied and will provide us with further information later.

He injured the knee while pushing a troley (sic) for servicing aircraft, and it was raining and he slipped onto the left knee.

he states he has had severe pain since the left knee (sic)

he does not feel he cannot work (sic) due to this pain

prior to this injury he did have some treatment over 6 months ago with an injectio (sic) by his PCP and was doing very well.

He was not referred to a specialist at that time as he was doing very well from his knee (sic) and was working without any difficulty

Now since the injury he is having pain and swelling and difficulty ambulating

***

The patient is taking aleve 2 pills twice a day for pain

***

The patient states he has limited flexion with occasional locking of the knee.

***

Physical Exam:

Left Knee

Inspection:	Moderate effusion. No erythema. No sign of infection. No skin lesions.
Palpation:	Significant medial joint line tenderness on exam. Crepitus on range of motion.
Range of Motion:	5-115 degrees. Significant pain after 90
Stability:	Stable to varus/valgus stress
Alignment:	varus 5 degrees
Other tests:	motor and sensation intact bilateral lower extremities feet warm and well perfused bilaterally

Studies:

4 views of the left knee:

no fractures noted

there is medial joint space narrowing with subchondral sclerosis and osteophytes

Diagnosis:

Left knee arthritis

Assessment:

The patient has a severe exacerbation of his arthritis from a fall at work on 7/2/2014 when he was pushing a trolley and he slipped onto his knee when it was raining. He has reported this to his work however his WC insurance is denying the case due to 'lack of documentation.'

He was working fine without difficulties prior to this injury however since the injury his knee pain has been exacerbated and he is having difficulties even ambulating.

He will likely need a knee replacement due to this exacerbation of the knee arthritis. In order to try to alleviate his symptoms we will try an injection today and physical therapy as well. Also I will order him medial unloader brace to offload the medial joint space.

he will continue with aleve

he does not wish to take time off work because he cannot afford to and his work is denying the claim" *** (Px.1)

On October 5, 2015, at the request of respondent, and pursuant to Section 12 of the Act, petitioner presented to Joshua J. Jacobs, M.D., for an examination. Dr. Jacobs recorded the following pertinent notes:

"On evaluation today, the patient recounted his history of injury. He stated he was working as an aircraft maintenance technician to load items during plane maintenance and pushed a cart on an incline. He states he fell onto his left knee on a ramp. He struck the front of his left knee. He stated that a coworker helped him up. He had immediate pain and swelling and experienced locking of his knee. He stated he was able to complete his shift. He reported the injury to his supervisors the next day and was seen by occupational health. I do

not have records from the time of the injury, nor do I have records from occupational health.

He noted that since the injury he has been given an unloader knee brace and prescribed physical therapy. He has had no relief from these interventions. He has continued pain and swelling. He notes that the knee locks when it is flexed, for example while he is driving. The pain awakens him at night. He states the pain is noted throughout the knee and occasionally radiates proximally to the mid thigh and distally to the mid shin. When he is walking, he rates the pain at 8/10 to 9/10. Stair climbing gives him 10/10 pain. His pain is noted to a lesser degree while sitting, and he rates this as a 4/5 out of 10. He specifically denied having a problem with his left knee prior to this incident, although this is not consistent with the medical records that were supplied in that he was treated by his primary care physician for osteoarthritis of his knee in March 2014." (Rx.1)

Dr. Jacobs found that petitioner sustained an accident when he struck his left knee on the ground on July 2, 2014. However, Dr. Jacobs opined that such accident may have temporarily exacerbated his left knee symptoms and that petitioner's need for a left total knee replacement is due to the underlying osteoarthritis and not to the work-related injury. Upon examining petitioner, Dr. Jacobs found that petitioner has a mild antalgic gait favoring the left lower extremity. He found that petitioner, in stance, has a 7° varus deformity of the right knee, and a 10° varus deformity of the left knee. Dr. Jacobs found that petitioner has tenderness in the region of the medial and lateral joint line of his left knee as well as of the medial and lateral patellofemoral facet. He has 2 cm. of calf atrophy on the left. (Rx.1)

Dr. Jacobs did not appreciate significant changes between the March 27, 2014 left knee x-rays and the July 12, 2014 left knee x-rays. (Rx.1)

Petitioner told Dr. Jacobs that he continues to work for respondent, but that he needs help from his co-workers. He told Dr. Jacobs that he is using a cane at all times, and complained of stiffness, swelling, weakness, catching, locking and giving way of the left knee. He told Dr. Jacobs that he has a severe limp. (Rx.1)

CONCLUSIONS OF LAW

In support of his decision with regard 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, 2014, as he was pushing a cart at work, he slipped and fell and landed on his left knee.

The records of Doctors Siddiqui and Levi indicate that petitioner gave histories of injuring his left knee at work on July 2, 2014.

Dr. Jacobs, respondent's Section 12 examining physician, took a history in which petitioner stated that while he was pushing a cart on an incline, he fell onto his left knee on a ramp. He recorded that petitioner struck the front of his left knee.

Based on the foregoing, the arbitrator finds that on July 2, 2014, petitioner sustained an accident that arose out of and in the course of her employment by respondent. Even Dr. Jacobs opined that petitioner sustained an injury at work on July 2, 2014.

In support of his decision with regard to issue (F) "Is the Petitioner's current condition of ill-being causally related to the injury?', the Arbitrator finds as follows:

When an employee with a pre-existing 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 pre-existing condition or whether the pre-existing condition alone was the cause of the injury. Generally, these will be factual questions to be resolved by the Commission. However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture. If there is an adequate basis for finding that an occupational activity aggravated or accelerated a pre-existing condition, and, thereby, caused the disability, the Commission's award of compensation must be confirmed. Sisbro v. Indus. Comm'n, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003)

Petitioner claims that the accident he sustained permanently aggravated the pre-existing condition of ill-being of his left knee to the point that he now requires a total knee replacement.

In support of petitioner's contention that the left knee condition is causally related to such accident, he has offered his own testimony concerning a change in the condition of his left knee from before the accident to after the accident, as well as the treating records and opinions of Dr. Levi.

The arbitrator notes that on April 20, 2014, Dr. Siddiqui wrote: "patient walked after injection expressed no joint pain and is happy." Dr. Siddiqui instructed petitioner to follow up with him in 3 months if the injection is effective. Dr. Siddiqui did not specify which knee he injected, and did not specify for which knee he recommended a brace.

The treating records in evidence show that, post-accident, petitioner first sought treatment with Dr. Siddiqui. He saw Dr. Siddiqui 8 days after the accident. The history recorded by Dr. Siddiqui on July 10, 2014 is consistent with the history to which petitioner testified at trial.

Petitioner came under the care of Dr. Levi on November 21, 2014, which was 20-2/7 weeks after the accident. Dr. Levi wrote that petitioner's left knee pain began on July 2, 2014, and that prior to this injury, he had some treatment over 6 months ago with an injection by his PCP and that he was doing very well. Dr. Levi ordered another round of x-rays of the left knee. However, there is no evidence in the record that Dr. Levi made any type of comparison of the post-accident x-rays with the pre-accident x-rays to determine if there were any objective changes in the osteoarthritis of petitioner's left knee. There is no evidence to indicate that Dr. Levi reviewed any of petitioner's pre-accident medical records. Instead, he relied entirely upon petitioner's history of having achieved, apparently, complete resolution of his symptoms following 1 injection to the knee prior to the accident. Notwithstanding these facts, Dr. Levi opined that the accident caused a "severe exacerbation" of the arthritis of his left knee to the point that he now needs a total knee replacement.

In rebuttal, respondent offered the opinions of Dr. Jacobs, their Section 12 examining physician. Upon examination, Dr. Jacobs found, among other things, a 10° varus deformity of the left knee and a 7° varus deformity of the right knee. With the exception of records from an occupational health clinic, Dr. Jacobs reviewed petitioner's medical records

from before and after the accident. Dr. Jacobs acknowledged that on July 2, 2014, petitioner sustained a work injury to his left knee. After reviewing such medical records, comparing the 2 sets of x-rays, and examining petitioner, Dr. Jacobs opined that petitioner "may have suffered a *temporary* exacerbation of his left knee *symptoms*" (Emphasis added), but that the need for a total knee replacement was due to the underlying osteoarthritis and not to the work-related injury.

Dr. Jacobs opined that petitioner may have suffered a temporary exacerbation of left knee symptoms, but how can he have a complete understanding of whether or not such exacerbation was temporary without reviewing the initial treating records from the occupational clinic?

Dr. Jacobs buttressed his causation opinion with his findings after he compared the pre-accident left knee x-rays with the post-accident x-rays. Dr. Jacobs did not appreciate significant changes between them.

Dr. Pinchcofsky's findings as to the March 27, 2014 x-rays of the left knee include the following:

"There is moderate medial and patellofemoral compartment joint space narrowing, tricompartmental osteophytic spurring, and prominence of the intercondylar eminence."

Dr. Pearce's impression, with regard to the July 12, 2014 x-rays of the left knee, offered the following impression: "Severe tricompartmental osteoarthritis."

The arbitrator notes that, in describing the degree of osteoarthritis, Dr. Pearce uses the word "severe" whereas Dr. Pinchcofsky does not. Notwithstanding this observation, the arbitrator finds it significant that Dr. Pearce makes no mention of any traumatically-induced condition of the knee such as a bone bruise. In fact, he specifically states: "There is no periosteal reaction or bone destruction."

The arbitrator now considers the credibility of petitioner.

When Dr. Jacobs examined petitioner on October 5, 2015, he wrote that petitioner "specifically denied having a problem with his left knee prior to this incident."

However, at trial, petitioner admitted to have problems with his left knee for several years.

When Dr. Levi examined petitioner on November 21, 2014, he wrote that petitioner's left knee pain began on July 2, 2014, and that prior to this injury, he had some treatment over 6 months ago with an injection by his PCP and that he was doing very well.

Petitioner testified to the following:

Q: Before the accident happened, how did you feel with respect to your legs? Did you continue to have problems before the accident after you were done treating?

A: No, it was good. After treatment, it was good. (Tr. 20)

However, petitioner also testified that the shots he received from Dr. Zaki Siddiqui would help a little bit for about 4 or 5 weeks, and then he would have a little bit of pain. Petitioner then testified that after he received the shots, his knees would be good for 2 or 3 weeks, and then for 2 or 3 months, his knees would not be good.

Petitioner told Dr. Jacobs that after he slipped and fell, a co-worker helped him get up. However, at trial, petitioner testified that he was alone at the time he fell, that a co-worker was inside the plane, and that he tried to get up and then got up.

Petitioner reported to Dr. Jacobs that he has a severe limp. Upon examining petitioner, Dr. Jacobs found that petitioner has a "mild antalgic gait favoring the left lower extremity."

Petitioner told Dr. Jacobs that the day after the accident, he reported such accident to his supervisors and was seen by occupational health. However, at trial, petitioner testified that soon after he fell, he reported the accident to a co-worker who was inside the plane, and that this co-worker reported petitioner's accident to the supervisor. Also at trial, petitioner made no mention of treating at an occupational health clinic the day after the accident.

The arbitrator questions petitioner's credibility.

The arbitrator has found that petitioner suffered an accidental injury to his left leg on July 2, 2014. He continued to work after such accident and has lost no time from work as a result of it. Before the accident, petitioner took Aleve to relieve the pain caused by his arthritic knees. After the accident, petitioner took Aleve for left knee pain. Before the accident, Dr. Siddiqui recommended a kneecap with knee brace. After the accident, Dr. Siddiqui recommended a knee support.

Consequently, the question is whether, on July 2, 2014:

1. Petitioner sustained a minor bump to his left knee that did not affect his osteoarthritis, or
2. Petitioner sustained a severe contusion to his left knee that exacerbated his osteoarthritis.

Petitioner testified that he treated for both knees before the accident, and treated for only his left knee after the accident. Yet, there is no evidence in Dr. Siddiqui's pre-accident records that he injected both knees or that he recommended a brace for each knee. Moreover, Dr. Levi's records suggest that petitioner received an injection to his left knee 6 months before he first visited Dr. Levi.

It is true that it was only after the accident that a doctor mentions the need for a left total knee replacement. But the first mention of a joint replacement was approximately 4½ months after the accident when Dr. Levi first saw petitioner.

The arbitrator concludes that by a mere preponderance of the weight of the evidence, petitioner failed to prove that the current condition of ill-being of his left leg is causally related to the accident of July 2, 2014.

It is true that respondent did not provide Dr. Jacobs with the occupational health clinic records for his review.

However, it is petitioner's burden of proof.

The arbitrator questions petitioner's credibility, and requires corroborating evidence with regard to the degree of severity of the contusion to petitioner's left knee.

No corroborating testimony from a co-worker that petitioner had difficulty getting up after the slip and fall or that he could not move for at least ½ hour was provided.

No records from the occupational health clinic, where petitioner first received treatment on the day after the accident, were offered into evidence.

On April 20, 2014, before he received an injection, petitioner exhibited slight swelling at the patellar area and no erythema.

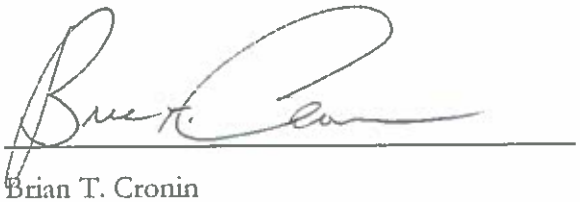
On July 10, 2014, 8 days after the accident, petitioner exhibited slight swelling at the patellar area, no erythema and no hematoma. Petitioner also exhibited slight swelling at the medial area. Petitioner has 10° of varus deformity of his left knee.

On July 12, 2014, Dr. Pearce opined the x-rays of the left knee show no periosteal reaction.

Furthermore, after Dr. Siddiqui injected petitioner's knee on April 20, 2014, he instructed petitioner to follow up in 3 months if the injection works. Petitioner next saw Dr. Siddiqui on July 10, 2014, which was more than 2½ months later.

The arbitrator finds that petitioner's statement to Dr. Levi that he was "doing very well" before the accident is simply not credible. Petitioner even testified that after he received the shots, his knees would be good for 2 or 3 weeks, and then for 2 or 3 months, his knees would not be good. Furthermore, the degree of varus deformity of the left knee was, and is, worse than that of the right knee.

Based on the foregoing, the arbitrator denies compensation for medical bills and prospective medical care.



2-20-2017

Brian T. Cronin
Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN ISENHART,

Petitioner,

vs.

NO: 14 WC 38475

VILLAGE OF MATTESON,

18IWCC0304

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, causation, temporary total disability, medical expenses, prospective medical, and penalties and fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below but attaches the Decision of the Arbitrator, which is made a part hereof, for the statement of facts with the modifications noted below.

Petitioner bears the burden of proving all the elements of the claim by a preponderance of the credible evidence in the record.

The Commission finds that Petitioner failed to prove that his accident arose out of his employment with Respondent. Petitioner further failed to prove causal connection between the alleged accident and his current condition of ill-being. Further, Petitioner sought treatment from multiple providers, and the Commission finds the treatment of Dr. Kaz exceeded the number of permissible providers under the Act. Finally, the Commission affirms the Arbitrator in his denial of an award for penalties and fees.

The Commission finds the Petitioner's testimony not to be credible. His testimony is not borne out by the treating physicians' records. It is not borne out by the testimony of Eileen Majda, and his veracity is called into question with the video surveillance and corresponding testimony of Erik Ekstrom.

"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). "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's incident occurred while he was in the course of his employment, but such incident did not arise out of his employment.

Petitioner testified at trial his foot merely gave out while he was working out. T. 13. Petitioner specifically denied that he twisted or rolled his ankle. T. 60, 88. Petitioner was standing and while pushing up with his shoulders/arms, he felt a pain in his ankle and his foot gave out. T. 13. Such mechanism of injury is borne out by the contemporaneous medical records as well as the accident reports. Petitioner presented to Ingalls Memorial Hospital immediately after the incident and provided the following history: "Pt states he was working out at work today around 2:30pm and his right foot gave out on him…" PX1. On November 10, 2014, the same history was memorialized by Ingalls Occupational Health- "Pt states he was working out at work today around 2:30pm and his right foot gave out on him…" PX1. On January 20, 2015, Petitioner sought treatment with Dr. Brian Burgess, DPM, a foot specialist, and associated his symptoms to a prior work injury advising the symptoms experienced on November 8, 2014 were the same symptoms he previously experienced. PX3. Both the "Employee Report of Accident/Injury" and the "Supervisor's Accident Investigation Report" memorialize "an injury" where Petitioner's foot "gave out" while performing a push-press. PX17 and PX18.

The Commission finds Petitioner was exposed to a personal risk when his foot gave out during his work-out. Our inquiry, though, does not stop there. "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/personal 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.

Petitioner's foot gave out during his work-out. As part of his contract, Petitioner was required to work-out (quantitative) and during his work-out (qualitative) his foot gave way, but there is absolutely no evidence Petitioner's work-out maneuver had any bearing on his foot giving

out. The maneuver Petitioner performed when his foot gave way was a lift with his arms while standing. There is no evidence the weight Petitioner lifted in any way affected his ankle. Petitioner injured his ankle not his shoulder. Correlation does not mean causation. The two are separate distinct concepts.

The Commission is free to draw an inference but such inference must be reasonable. "Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot be reasonably drawn. [citations omitted]." *First Cash Financial Services v. The Industrial Commission*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799 (2006). To draw such an inference with these facts, the Commission believes would not be reasonable. As such the Commission declines to do so.

Even assuming *arguendo*, Petitioner sustained an accident, Petitioner failed to prove a causal relationship between his current condition of ill-being and need for treatment. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith Corporation v. Industrial Commission*, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972).

Dr. Burgess evaluated Petitioner initially on January 20, 2015. As previously indicated, Petitioner provided a history of experiencing symptoms on November 8, 2014 which were the same symptoms he experienced in association to a prior work injury. PX3. MRIs of the foot and ankle were performed on January 27, 2015 both of which were negative for any acute pathology. PX3. During Petitioner's visit of March 12, 2015, he provides a history of running and squatting causing a sharp pain which is consistent with the video surveillance evidencing Petitioner working out at the gym. RX9 & RX10. Given Petitioner's subjective complaints of pain which the Commission finds questionable, an ultrasound is performed on April 30, 2015 which evidences a thickened right talofibular ligament consistent with a previous partial tear as well as possible impingement. On May 7, 2015, Dr. Burgess diagnoses "persistent pain s/p right ankle sprain; anterior lateral right ankle impingement; and right anterior distal tibial osteophyte" and recommends "right ankle arthroscopy with anterior lateral decompression and resection or anterior distal tibial osteophyte." PX3. Dr. Burgess did not provide a causation opinion.

Thereafter, Petitioner, at the direction of his attorney, seeks treatment with Dr. Ari Kaz. Dr. Kaz provided his causation opinion via evidence deposition taken on November 18, 2015. Dr. Kaz diagnosed Petitioner with a previous partial tear of the ATFL as well as an osteophyte. PX9, p. 9. Dr. Kaz ultimately recommended arthroscopic surgery as did Dr. Burgess but also recommended an ankle reconstruction. Unlike Dr. Burgess, Dr. Kaz provided a causation opinion stating Petitioner's injury of November 8, 2014 lead to the need for treatment and surgery. PX9, p. 14-15. Critically, though, Dr. Kaz predicated his opinion on a faulty understanding of Petitioner's mechanism of injury. Specifically, Dr. Kaz testified Petitioner sustained a twisting injury as well as dorsiflexing (rolling) his ankle which caused a sprain. PX9, p. 16. Such mechanism of injury is simply not borne out by contemporaneous medical/accident records or more importantly, Petitioner's testimony. "Expert opinions must be supported by facts and are only as valid as the facts

18IWCC0304

underlying them. Quoting *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87 (2003)." *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC, ¶24. As such, the Commission affords little weight to the opinion of Dr. Kaz.

Instead, the Commission affords greater weight to the opinion of Dr. Armen Kelikian. Dr. Kelikian evaluated Petitioner on several occasions pursuant to Section 12 of the Act at Respondent's request and provided his evidence deposition on June 29, 2015. Dr. Kelikian testified Petitioner suffered from Achilles tendinitis which was not associated with Petitioner's incident of November 8, 2014. RX11, p. 20. Further Dr. Kelikian reviewed both the MRI and ultrasound and disagreed with the findings of impingement or osteophytes. RX11, p. 23. Dr. Kelikian performed an additional procedure using a fluoroscope which he described as a live x-ray machine which failed to evidence impingement or osteophytes of any significance. RX11, p.23. As Dr. Kelikian explained, the prominence seen in Petitioner's ankle were within normal limits and did not affect the ankle's movement. *Id.* Dr. Kelikian testified no further treatment was recommended for Petitioner's subjective complaints of pain.

Dr. Kelikian's testimony as it related to the exact mechanism of injury was a bit confusing. Dr. Kelikian initially appeared to base his causation opinion on an accident which occurred in 2013. Such confusion was rectified on cross-examination, when Dr. Kelikian was presented with an accurate history as to the incident of November 8, 2014. Dr. Kelikian testified Petitioner did not sustain an injury but merely reported symptoms as there was no minor nor major trauma. RX11, p.40. The Commission finds Petitioner failed to prove a causal relationship between the incident of November 8, 2014 and his current condition of ill-being.

The Commission further finds that even had Petitioner proven accident and causation, any medical expenses incurred, or treatment recommended to be performed by Dr. Ari Kaz, is denied as Dr. Kaz is Petitioner's third choice of physician. Petitioner initially sought treatment of his choosing with his chiropractor, Dr. Nick Mallios. His second choice of physician, albeit at his attorney's direction, was Dr. Brian Burgess. Dr. Kaz was outside the chain of referrals and was Petitioner's third choice of treater.

The Commission affirms the Arbitrator in the denial of penalties and fees. As accident and liability were disputed, Respondent was reasonable in denying payment, and therefore penalties were correctly denied.

The Commission finds Petitioner failed to meet his burden of proof, and hereby reverses the Arbitrator's decision on the issues of accident and causation. The Commission further denies the treatment of Dr. Kaz, as Dr. Kaz is outside the chain of referrals. The Commission concurs with the Arbitrator in his denial of penalties and fees. All other issues are deemed moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, dated June 17, 2016, 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.

18IWCC0304

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: MAY 16 2018
CJD/dmm
O: 032118
049

Joshua D. Luskin

L. Elizabeth Coppoletti

PARTIAL CONCURRENCE / PARTIAL DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove accident and causation. I would instead affirm the findings of Arbitrator Andros and find that Petitioner did prove he suffered from an injury to his right ankle as a result of his work-related activities, and is entitled to reasonable medical expenses, temporary total disability, and a remand to the Arbitrator for a determination of further benefits. However, I concur with the majority regarding the denial of penalties and fees, and the denial of treatment of Dr. Kaz on the grounds he fell outside of the chain of referrals.

The Petitioner was employed by Respondent as a firefighter/paramedic and was working out on November 8, 2014, as part of the demanding physical requirements of his job. While lifting weights, Petitioner's ankle gave way, and he immediately reported the incident to his supervisor and sought medical treatment at a facility chosen by his employer. As part of his claim, Respondent sought a utilization review of Petitioner's treatment. Petitioner's treatment on November 8, 2014 after his initial injury, further treatment on November 10, 2014 with Occupational Health, 6 visits with Dr. Millos, and the treatment with Dr. Burgess, were all certified as reasonable and necessary related to his work injury, by the insurance provider. Utilization reviews were not entered into evidence regarding the orthopedic care of Petitioner.

Petitioner sought conservative care for his right foot and ankle from multiple providers – urgent care, holistic chiropractor, podiatrist, physical therapist, and ultimately an orthopedic surgeon. Petitioner underwent manipulations, acupuncture, a cortisone injection, physical therapy and work hardening, and yet his condition did not improve. The ultrasound performed on Petitioner, whom Respondent's expert conceded was one he referred patients to, showed a thickened right ATFL consistent with previous partial tear, and a prominent osteophyte of the right distal tibia. (Px3; Px9 p. 9) As conservative measures failed, and Petitioner still has not been able to resume fully duty, Respondent's section 12 examiner recommended an FCE to determine Petitioner's current level of limitation, and Petition's orthopedic surgeon recommended arthroscopy. Petitioner was working full-duty as a firefighter/paramedic before the November 8, 2014, incident, and has not been able to resume full duty since that time as a result of the problems he has with his right foot and ankle.

Respondent produced 2 live witnesses, as well as the deposition of their IME physician. These witnesses were put forth to try and make Petitioner out to be a faker/malingerer, and/or to propose he has exaggerated the extent of his injuries. Respondent's witnesses were not terribly persuasive. The testimony of the benefits manager for the village, Eileen Majda, was in essence that when she would see Petitioner, he would walk normally unless he thought he was being

18IWCC0304

watched, at which time he would limp. By Petitioner's own testimony, the pain was intermittent, so it is logical that he would not walk normally nor walk with a limp, 100% of the time. The other live witness for Respondent, a private investigator, Erik Ekstrom, conducted surveillance on Petitioner working out. However, with the exception of walking on a treadmill, the video and report only showed Petitioner doing upper body exercises, so the fact Petitioner was at the gym while off work, was not terribly persuasive. Respondent's IME physician did not believe there was accident, and testified he was unimpressed with the medical records and assessments of Petitioner's treaters. He did agree that Petitioner did need an FCE to determine the extent of Petitioner's limitations, and ultimately conceded that the thickened right ATFL on the ultrasound would not have been genetic since it was only on the right side. (Rx11 p. 65)

Based on the above, I would find that Petitioner sustained a compensable accident that arose out of and in the course of his employment and that he is entitled to medical expenses in the amount of $18,894.87, temporary total disability from November 9, 2014 through July 19, 2015, and the matter remanded to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Charles J. DeVriendt

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

ISENHART, BRIAN
Employee/Petitioner

Case# **14WC038475**

VILLAGE OF MATTESON
Employer/Respondent

18IWCC0304

On 6/17/2016, 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:

4788 HETHERINGTON KARPEL BOBBER
W JOSEPH HETHERINGTON
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
CYNTHIA A FREUND
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

18IWCC0304

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)

Brian Isenhart
Employee/Petitioner

v.

Village of Matteson
Employer/Respondent

Case # 14 WC 38475

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 **January 27, 2016, February 25, 2016 and March 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 current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **November 8, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$82,451.20**; the average weekly wage was **$1,585.60**.

On the date of accident, Petitioner was **39** 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 **$24,240.52** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$3,000.00** for other benefits, for a total credit of **$27,240.52**.

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

ORDER

Temporary total disability
Respondent shall pay Petitioner temporary total disability benefits of **$1,057.07**/week for **36 1/7** weeks, from **November 8, 2014** through **July 19, 2015**, as provided in Section 8(b) of the Act.

Temporary partial disability
Respondent shall pay Petitioner temporary partial disability benefits of **$660.67**/week for **32 4/7** weeks, from **August 7, 2015** through **March 21, 2016**, as provided in Section 8(a) of the Act.

Medical expenses
Respondent shall pay Petitioner & his attorney **$15,153.87** for medical expenses, including the bills of Ingalls Occupational Health ($520.00), Dr. Nick Mallios/Bolingbrook Wellness Center ($995.00 per UR), Dr. Brian Burgess/Hinsdale Orthopaedics ($5906.00 per UR), Athletico ($6083.87 per UR), Naperville Medical Imaging ($658.00) and Dr. Ari Kaz/Illinois Bone & Joint Institute ($991.00).

Prospective medical treatment
Respondent shall authorize in writing and pay for the right ankle surgery recommended by Dr. Ari Kaz of Illinois Bone and Joint Institute.

Penalties/Attorney's fees
Respondent shall pay to Petitioner penalties of $0, as provided in Section 19(l) of the Act.

Respondent shall pay penalties of $0., as provided in Section 19(k) of the Act.

Respondent shall pay attorney's fees of $0., as provided in Section 16 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

June 15, 2016
Date

ICArbDec p. 2

JUN 17 2016

ISSUES 14 WC 038 475

Petitioner, a 39 year old firefighter/paramedic, alleges a right ankle injury at work on November 8, 2014. He claims temporary total disability benefits from November 9, 2014 through July 19, 2015; temporary partial disability benefits from August 7, 2015 through March 21, 2016, the last hearing date; medical expenses; prospective medical treatment including surgery ; and penalties and attorney's fees. Arb Exh 1. Three persons testified over multiple hearing dates.

FINDINGS OF FACT

Petitioner began his career with Respondent as a full-time firefighter/paramedic on September 26, 2004. T1 (transcript of January 27, 2016 hearing) at 11. He is married with two children. He explained he is in the career which was his goal since he was a boy. On November 8, 2014, he was working out in the designated workout room at the fire station, as required by the contract between Respondent and its firefighter/paramedics. T1 at 12. This employer does not dispute the requirement of physical conditioning for firefighters in the case at bar.

His workout that day consisted of weight lifting. One of his lifts was a military push press, a maneuver in which he first lifted weight to a neutral position, then dropped down into a squat and then did an explosive push up. As he did the explosive upward push, he felt a sharp pain in his right ankle and foot, his foot gave out on him and he immediately dropped the weight. T1 at 12-13.

At page 12, line one he explained that he injured his right ankle and foot. The precise details of the body mechanics of this military push press and ensuing trauma is explained in precise detail particularly in pages 12 through 13, notably lines 10-15 then 18 & 19. The lift seemed to fail on the upward movement as this Arbitrator understands the mechanics and force involved. As summarized below, at page 13, lines 18 & 19 he experienced pain in the right ankle and foot, there was swelling starting to begin, as he stated. His explanation is adopted.

In summary fashion of his detailed testimony, Petitioner's right ankle and foot began to swell immediately after the accident, and he was not able to bear weight on the foot. T1 at 13-14.

He reported the accident immediately to his supervisor, Commander John Coburn: shortly thereafter, and he and Commander Coburn prepared accident reports. T1 at 14, PX 17 and 18. Much ado at the first hearing was made about whether the Commander's paperwork via the interview taken with the Petitioner failed as a business record inter alia since the Commander did not scribe the same on the letterhead of the department. Petitioner was emphatic that he notified his commanding officer, they met and they separately filled out accident forms for the village with the worker seeing the Commander fill out and sign his form in the workers presence. No legally significant difference is reflected or inferred by the forms. The Arbitrator finds herein the reports prepared by the Commander in front of the Petitioner and during their interview is a business record exception to the hearsay rule. A lay witness from the department later confirmed the authenticity of the Commanders signature.

The Petitioner was then directed by Commander Coburn to Ingalls Urgent Care, where x-rays were taken and he was given pain medication and crutches. T1 at 15, PX 1. The record shows this emergent care facility/ emergency department is on 159th in Tinley Park; some of the pages in the exhibit show the treatment as in an emergency room. By its own document the exhibit pages also show this facility is housed in the same building complex as the Ingalls Occupational Health, which I deem the company doctors, under the workers compensation general characterization.

Specifically, at page 15,line four , the Commander advised and directed the worker to go to the Ingalls center. Petitioner had severe pain in the right foot and ankle, problems with weight bearing and was treated with ex ray, pills and crutches (and obviously- medical advice).

In summary, Petitioner followed up by direction of the Ingalls treating providers giving emergent care (note the top of the records noting emergency room) to Ingalls Occupational Health in the same building per the addresses in the record. This took place two days later because of continuing pain in his right ankle and foot. He was examined and advised to continue his medications, to elevate and ice the ankle and foot and to continue to use crutches.

As to work status, the firefighter was given a light duty (work) release, but Respondent did not have light duty for him at that time. T1 at 15-16, PX 1.

In analyzing the issue under section 8 regarding choice of doctors and referrals, the Arbitrator finds the chain of referrals supra does not proof he was outside the chain of referrals entitled by law in the Act and by case law. Section 8 limitations are to avoid abuse of the system in terms of doctor shopping, so to speak. No such abuse is found or based upon and reasonable inference in the evidence in the case at bar.

The evidence in the transcript is testimony beginning at page 16, lines 7-9: (upon the last visit, he was) provided another assessment and mentioned to me (firefighter) if I wanted to seek other medical attention through another doctor, I could do that. As such, he followed up with his own personal physician, Dr Mallios.

Authorization by the company doctor to seek another doctor, name unspecified for medical attention, particularly by an "occ med" doctor housed in the same building as the doctors providing emergency room care , name unspecified, never has been ruled a break in referrals. Thus, the Arbitrator finds the referral to seek another doctor as in the company doctor's initiated "chain" of referrals.

Petitioner was treated by Dr. Nick Mallios two days later, and was under his care from that time until January 19, 2015. Dr. Mallios treated Petitioner's right ankle and foot with manipulations and acupuncture/trigger point therapy. As to work status, he held him off work. Petitioner's condition improved as a result of the treatment to the point where he was able to get off crutches six weeks after the accident on November 18th at T1. 19, but then the improvement plateaued, and Dr. Mallios recommended that he see a specialist. T1 at 16-20, PX 2.

The Arbitrator concludes under section 8 that this referral to a specialist keeps the treatment in the chain of doctors sourcing from the Occupational medical doctor/PA-C at Ingalls Occupational Health, housed with emergency services practice at Ingalls on 159th in Tinley Park.

Petitioner saw Dr. Brian Burgess, a podiatrist, i.e. a foot specialist on January 20, 2015 at the group Hinsdale Orthopedics, thereafter continuing under his care from that date until May 7, 2015. Specifically at page 20, lines 5 & 6 when asked if Dr. Mallios made any recommendation the firefighter replied Yes, to find a more(?) specialist. And no, he never released me to work. T1, page 20.

As to the podiatrist's care- at his initial visit (page 20, line 10) , Dr. Burgess ordered an MRI of the right ankle, which showed a tibiotalar joint effusion, and an MRI of the right foot, which showed changes at the first metatarsophalangeal joint (page 21) . He also ordered physical therapy. Petitioner received the therapy at Athletico near 127th & Harlem in the area from Jim Beese, a therapist who specializes in ankle and foot injuries, from February 13 through March 11, 2015. T1 at 20-23, PX 3 and 4.

Petitioner returned to Dr. Burgess on March 12, 2015, and Dr. Burgess ordered two more weeks of physical therapy to be followed by work conditioning. Petitioner received the additional therapy at Athletico from March 16 through March 27, 2015 and then underwent work conditioning for four hours a day, five days a week from March 30 through April 15, 2015. During the work conditioning he performed lower body exercises, including explosive exercises that simulated the work tasks of a firefighter/paramedic. As he performed those exercises he began having increased pain in the right lateral ankle, and Mr. Beese recommended that the work conditioning be discontinued. T1 at 23-25, T2 (transcript of February 25, 2016 hearing) at 67-70, PX 3 and 4. The firefighter's testimony was that his foot was getting worse (during work conditioning, 4 hours per day, five days per week). See page 24, lines 1-6. At page 24, line 18-20 this firefighter said the pain was in the ankle, starting at the midpoint in the front, going around under the ankle to the Achilles. At page 25, line 1-2 he said the pain was on the outside, lateral part.

He returned to Dr. Burgess on April 16, 2015 ordering an ultrasound of the right ankle. The 4/30/15 ultrasound was read as thickening of the right anterior talofibular ligament consistent with a partial tear and an osteophyte within the anterior compartment of the ankle joint. T1 at 35, PX 3.

Shortly thereafter Dr. Burgess recommended arthroscopic surgery on the right ankle to release lateral impingement and to resect the osteophyte. Petitioner agreed to have the surgery because he wanted his foot to get better so that he could get back to work (page 26,lines 13-14 ; He further testified at page 27 that the surgery was not done, workers compensation refused surgery. His last visit then was May 7, 2015. Some of his charges are denied supra via UR.

As to work status, Dr. Burgess kept Petitioner off work entirely during the period when Petitioner was under his care. However, on July 13, 2015 he released Petitioner for light duty at Petitioner's request to attempt to try and return to work, prescribing/ordering work restrictions of no lifting greater than 15 pounds, no running, jumping, squatting or kneeling and no ladder climbing. T1 at 27, PX 3.

Petitioner returned to light duty pursuant to Dr. Burgess' release on July 20, 2015, which was the first day when Respondent made light duty available to him. For the next two weeks he did office work for 40 hours per week. This work required him to do a significant amount of walking between the offices at the fire station and between the offices and two sides of the stations and cross the bay to where the firefighters' stay. As a result of this walking he began to experience so much pain in his right ankle and foot, difficulty weight bearing such that he had to start using crutches again. See page 29, lines 4-5 & lines 13-15. During insightful cross examination the firefighter asserted that he used crutches on and off.

Relative to work status, at that point Dr. Burgess restricted him to 15 hours of light duty work per week. He had started losing time and obtained a new order regarding the light duty return to work status. Thus, through his chief he returned to work for five hours per day, three days per week, on August 7, 2015, and he has been working on this reduced schedule ever since to the present date of testimony at the IWCC. T1 at 27-30, T2 at 97-98, 111-112, PX 3.

As stated infra, relative to the bills submitted for Dr. Burgess, the Arbitrator finds the Respondent is not liable for the charges of service for PT on March 9, 11, 16, 18, and 20 of 2015. The Arbitrator adopts the Respondent Exhibit 8, being the utilization review opinion by Dr. Junaid Makda M.D, American Board of Othopedic Surgery , Il license # 036129710 in denying the charges of those five therapy treatment/visits.

Relative to the bills of Dr. Nick Mallios, the charge for the orthotic shoe insert for the opposite, left foot is denied. The Arbitrator adopts Respondent Exhibit 7, being the utilization review by the above physician. Relative to the bills of Dr. Mallios for 19 dates of therapy, the charges for the first array of therapy are awarded for treatment inclusive from November 12, 2014 through December 1, 2014. The charges are denied for charges after that date through January 19, 2015. The Arbitrator adopts the conclusions in Respondent Exhibit 6, the utilization review report for modification.

All other bills are found and awarded as reasonable and necessary under section 8. The opinion basis for the finding is the testimony of Dr. Ari Kaz M.D. of Illinois Bone and Joint Institute.

He treatment continued but with a doctor of his own choice. Petitioner saw an orthopaedic foot and ankle specialist with Illinois Bone and Joint Institute namely Dr. Ari Kaz on August 18, August 31 and September 21, 2015.

Dr. Kaz made numerous positive findings on examination, including swelling of the right ankle and foot, diminished range of motion in the ankle, instability of the ankle and tenderness over the anterior talofibular (ATF) ligament and the anterior-inferior tibiofibular ligament. Based on these findings, as well as the findings on the April 30, 2015 ultrasound, he made a diagnosis of persistent right ankle pain with impingement syndrome, ATF ligament tear and distal tibia anterior osteophyte, and he expressed the opinion that these conditions were causally related to Petitioner's November 8, 2014 work accident. Like Dr. Burgess, he recommended arthroscopic surgery to include evaluation of the ankle joint for instability, removal of the distal tibia osteophyte and ankle ligament reconstruction to address the ATF ligament tear. Once again, Petitioner agreed to have the surgery, but Respondent refused to pay for it. T1 at 30-32, PX 10 (deposition of Dr. Kaz) at 7-14. The Petitioner testified that he thought the recommendations for surgery were similar as given by both Dr. Burgess and Dr. Kaz.

The Arbitrator adopts the opinions of Dr. Ari Kaz in the case at bar. The testimony of Dr. Kaz was far more specific and logical and probative than that of Dr. Armen Kelikian, who Dr. Kaz acknowledged is a fine doctor. Dr. Kaz explained the results of the ultrasound and how the injection was diagnostic, not therapeutic. P6:36 & P12:45. His options, recommended surgery, current diagnosis and impingement issues spans the entire page 13 of his deposition that needs to be read in haec verba to understand a succinct explanation of the medical aspects of the case at bar. This firefighter needs surgery for repair of his ATFL tear.

Again, Dr. Kaz's opinions are adopted in total. The doctor in well organized fashion yet simple language underscores affirmative causation at P14: 15-25. That ties with clarity into his adopted explanation of the mechanism of injury, P15: 9-19. The Causation to the ATFL tear is spelled out in detail on P16. As to the need for treatment and it's causation to the ATFL tear, the doctor spelled out that relationship at P16:13-18. Doctor explained the need for surgery is causally connected to the accident at bar. P17: 1-5. In his present condition he can not work as a fireman, "not at full duty" P17:6-10.

The patient's prior treatment is reasonable and necessary P19 and the bills are reasonable P20:1-2 & 8-18 , although essentially chiropractic case is not always therapeutic in foot cases. The Arbitrator has adopted the utilization review opinions relative to therapy.

After detailed explanations of both anatomy of the foot and ankle and later telling how emergency room doctors historically and classically provide exceedingly unreliable evaluations in foot cases, the Arbitrator adopts Dr.Kaz' statement P18:2-4 that Dr. Kalikian is a wonderful doctor but he (Dr. Kaz) doe not agree that its (this case) an aggravation of a preexisting condition. Dr. Kaz on detailed cross examination at P37: 16-24 compares the documented findings of Dr. Burgess of Hinsdale Orthopedics to his own updated testing. Dr. Kaz convincingly asserts the osteophyte is a <u>new</u> finding. (emphasis added)

In follow up, Dr. Kaz strongly as if print could speak disagrees with Dr. Kalikian in Dr. Kelikian's assertion that there is "no known accident' (emphasis added) That assertion of no known accident seemed to link Dr.Kelikian's commentary that the records of treatment were "garbage", as the doctor expressed in the deposition concluding that he should be quoted. The Arbitrator so quotes.

At the present time Petitioner credibly asserts has persistent daily pain in his right ankle and foot which is aggravated by walking, standing and other activities. As a result, he has to avoid activities which he previously engaged in, including both work activities and recreational activities such as running, bike riding, weight lifting, ice-skating and playing soccer with his son. T1 at 34-37.

He continued to do upper body weight lifting exercises for eight or nine months after the accident, T1 at 36-37; In fact, surveillance video that was offered into evidence by Respondent showed him doing these exercises at his health club on January 13 and January 15, 2015. RX 10. Also, once he was off crutches, he did some lower body weight lifting exercises on Dr. Mallios' advice to test what his injured ankle and foot would tolerate, but he had to stop these exercises after a short period of time because they caused him pain. T2 at 63-66.

Given the propensity of this first responder to train, exercise and weight lift given his job duties it is reasonable to expect that he would push himself to the maximum to recover as quickly as possible even it means testing his condition, so to speak.

Petitioner never injured his right ankle prior to his November 8, 2014 accident. He did, however, injure his right foot on September 6, 2013 when he stepped off the fire truck while responding to an alarm. He received treatment for this injury from Ingalls Urgent Care/Ingalls Occupational Health, Dr. Nick Mallios and Dr. Simon Lee. The documentary evidence confirmed petitioner's testimony that the injury was mainly confined to his right first metatarsophalangeal joint. He was off work as a result of this injury until December 17, 2013. From that time until his November 8, 2014 accident he had no problems with his right foot or ankle and no difficulty performing his duties as a firefighter/paramedic. T1 at 39-42, PX 5, 6, 7.

Petitioner was examined by Dr. Arman Kelikian at Respondent's request on February 9, 2015. Dr. Kelikian made no findings whatsoever regarding Petitioner's right ankle, even though all of the previous providers, and especially Dr. Mallios and Dr. Burgess, had found evidence of an ankle injury; in fact it is not clear from Kelikian's report that he even examined the ankle. He confused Petitioner's November 18, 2014 accident with his September 6, 2013 accident and then went on to make the statement that "[t]here was no known accident" at all. Kelikian Deposition Exhibit 2. Respondent denied liability for Petitioner's claim based on this statement. PX 20, Exhibit C to Petition for Penalties and Attorney's Fees.

Petitioner was reexamined by Dr. Kelikian at Respondent's request on June 9, 2015. Dr. Kelikian's report regarding this examination showed that he was still confusing the November 8, 2014 accident with the earlier accident and that he was confused about other things as well.

For example, he claimed to have reviewed a record of Dr. Giannoulias from December 5, 2014 with a diagnosis of right wrist – MCP problem, when in fact Dr. Giannoulias saw Petitioner on December 5, 2013 for his right big toe – MTP injury. Similarly, he claimed to have reviewed a record of Occupational Health from February 2, 2015, even though the last time Petitioner went to Ingalls Occupational Health was on November 10, 2014. Kelikian Deposition Exhibit 4.

Dr. Kelikian gave an evidence deposition on June 29, 2015. He testified on direct examination that he did not think Petitioner has an anterior impingement and therefore he does not think he needs surgery. RX 11 at 23. Yet on cross he accepts the ultrasound pathology. On cross examination he acknowledged that the April 30, 2015 ultrasound showed thickening of the ATF ligament consistent with a partial tear; that an incident in which a person's foot gives way while he is lifting a barbell is capable of causing a partial tear of the ATF ligament; that Petitioner complained of pain in the area around the ATF ligament; that he himself noted tenderness in that area in his June 9, 2015 examination; that thickening of the ATF ligament can cause an anterior lateral impingement; and that therefore it was not totally unreasonable for Dr. Burgess to recommend an anterior lateral decompression. This is so especially after he received the April 15, 2015 work hardening report from Athletico which showed that progress in work conditioning was limited by right lateral ankle pain and dysfunction. RX 11 at 48-55. He also acknowledged that he did not release Petitioner to return to work after either of his examinations; instead, he recommended a functional capacity evaluation to see what Petitioner was capable of doing. RX 11 at 55-56.

This Arbitrator finds the direction of Dr. Kelikian's conclusory opinion to be totally misplaced given his reliance on records having nothing to do with the case at bar plus finding no known accident to be totally unreliable plus, reluctantly stated- his citing of records totally unrelated to the case at bar gives rise to a total rejection of him as an expert in this case , and, unfortunately, somewhat of an embarrassment given Dr. Kaz's acknowledgement essentially of Dr. Kalikian's position in the medical community. Given his mis-direction and mis-reliance on non probative records i.e. a big toe injury plus wrist injury, its not unexpected that he lashes out against the treating doctors and their record annotations at deposition. Dr. Kelikian's opinion is totally rejected in this one case.

Ms. Eileen A. Majda testified on behalf of the Respondent. She identified the signature of John Coburn. One document provides contemporaneous documentation by history of the firefighter performing a push/press holding two 25# dumbbells, the employees right foot "gave out". Based upon the questioning of the Petitioner about the equipment, barbell v. dumbbells etc, The Arbitrator infers the claims agent did little in terms of investigation with the Commander , contributing to the misplaced denial of 'accident".

The key element of Ms. Majda's testimony was she observed him before Thanksgiving to be walking fine, not favoring or limping in any way, with crutches under his arms, but (seemingly) no pressure being put on them she saw him. Nothing was noticeable in his gait. However, she stated that he was using the crutches and limping. At a wake of a coworker sometime later her observation was somewhat the same. T P. 23-26.

A detailed review of the documentary medical evidence shows a consistent reporting by this first responder that his foot pain and gait issues are variable. Moreover not one doctor has every insinuated, alluded to, made a direct reference or even scribed that this firefighter is a symptom magnifier or malinger post accident in the case at bar. Thus, the testimony of this layperson's observations is not determinative on any part of the causation issue or the issue as to the firefighter's reliance upon, or , the accuracy of the treating doctors' off duty and or light duty restrictions.

The medical records have a consistent theme that the petitioner lower extremity was injured while weightlifting. The electronic as well as the triage short, fill in the blank type of History sections at times uses the word foot yet at other times uses the word ankle and sometimes both. The Arbitrator concludes nothing in all the records in evidence belies the firefighters description of the trauma or the complained of physical complaints to said lower extremity.

Petitioner was not impeached nor was his testimony eroded despite protracted, well organized, persistent cross examination. The Arbitrator has viewed multiple times the video evidence in the gym via a camera in the investigators gym bag. I see nothing to impeach the testimony of the Petitioner nor clearly show this firefighter violated any doctor's instructions.

Petitioner was a credible witness based upon his response to questions, his serious interest to provide direct, articulate answers to hours of questioning, and his informative responses in the actual body mechanics of the push/pull military press with dumbbells establishing a logical, clear mechanism of accident. He sought clarification to some convoluted questions and double negatives which, in the legal process, do account for some need for clarification.

This exact, precise explanation is not unexpected from a firefighter dedicated to physical fitness to maintain his position and his career; his approach to rehabilitation that includes weightlifting, seeing a physician who is also a kinesiologist, is totally consistent. He was forthright in testifying that at times he may experience more pain that at other times and the limping is not always constant. He seemed to have a genuine desire to get his right ankle problem corrected and return to work in his lifelong career goal as a firefighter/paramedic. That is consistent with his testimony of this post accident goal he set for himself mirroring his goal of his youth to become a fireman. His work with this primary treating doctor certainly matched well with this endeavor on the firefighter's part.

All the exhibits admitted in the transcript have been studied in detail. Admissibility of proffered exhibits needs to be addressed herein. Objections are ruled in the depositions, one in the original transcript that was prepared before close of proofs, testimony on 2/25/16.

Petitioner exhibit 7 at page 84 is admitted. It is deemed the record of Dr. Simon Lee who treated the petitioner in providing a second opinion in an injury to his foot in 2013, In reviewing said document it is clear the treatment to the foot in 2013 is not in the same part or for the same condition as is lower extremity injury in the case at bar. It is admitted as a record of treatment.

Petitioner exhibit 8 at page 88 is rejected as hearsay . It is deemed a section 12 report provided by a retained expert for this same Respondent but in the matter of a 2013 injury. The offer of same was to show the prior injury was to unrelated part of the lower extremity ,thus essentially section 12 examination reports are not per se barred as hearsay.

Petitioner exhibit 19 at page 95 is rejected as hearsay. It is the last of reports of the section 12 reports prepared by Dr. A. Kelikian, the Respondent's retained expert in this case at bar. It was offered as admissible as the report , copied to Petitioner counsel, addressing the surveillance video taken of the Petitioner given said video (reviewed by the doctor)was admitted via the testimony of the undercover operative in the gym.

Conclusions of Law 14 WC 038 475

Issue C: Accident

Petitioner testified that he was injured while weight lifting during a required workout in Respondent's workout room. This testimony was consistent with the histories he gave to all of his medical providers. PX 1-4 and 9. It was also corroborated by both his own accident report, PX 17, and the accident report of his shift commander. PX 18. The varied recordation of the words foot or ankle or both foot and ankle in triage history or electronic notes or by hand do not erode the direct testimony of the Petitioner.

Based upon the totality of the evidence, the Arbitrator therefore finds as a matter of law and a conclusion of fact that the Petitioner in the case at bar did sustain an accident that arose out of and in the course of his employment with Respondent in the case at bar as he alleged.

Issue F: Causal Connection

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and conclusions of fact that Petitioner's current right ankle and foot problems are causally related to his November 8, 2014 accident. This finding is supported inter alia by the following upderscored points :

1. The testimony of Petitioner that he did not injure his right ankle prior to the November 8, 2014 accident and that he has had serious problems with his right ankle and foot ever since the accident.

2. The records of all of Petitioner's medical providers since the accident, PX 1-4 and 9. These records show consistent complaints of right ankle and foot problems starting with the accident.

3. The records of the medical providers who treated Petitioner following his September 6, 2013 accident. PX 5-7. Those records show that the primary injury that Petitioner sustained as a result of that accident was to his right first metatarsophalangeal joint, which is anatomically quite distant from the ankle.

4. Petitioner's testimony that he had no problems with his right ankle or foot and no difficulty performing his duties as a firefighter/paramedic from December 17, 2013, the date when he returned to work following the September 6, 2013 accident, until the November 8, 2014 accident.

5. The testimony of Dr. Ari Kaz that the conditions of ill-being that he diagnosed -- persistent right ankle pain with impingement and ATF ligament tear -- are causally related to the November 8, 2014 accident. PX 9 at P14: 15-25 & P15: 9-19 & P16: 13-18 & P17:1-5.

Contrawise, the absolutely glaring mis- application of some of the old records by Dr. Kelikian totally erodes opinions and even his very basic usage in defense of this specific as an expert witness.. The lack of tendering the third and final report of this section 12 doctor leads to negative inferences as to its content. Reliance upon Dr. Kelikian was clearly unreasonable in the case at bar.

Issue J: Medical Expenses

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and conclusion of fact that the medical services provided by Ingalls Occupational Health, Dr. Nick Mallios/Bolingbrook Medical Center, Dr. Brian Burgess/Hinsdale Orthopaedics, Athletico, Naperville Imaging and Dr. Ari Kaz/Illinois Bone & Joint Institute were reasonable and necessary under section 8- except for those charges disallowed or modified in Respondent Exhibits 4 through 8. . The finding is supported inter alia by the following:

1. The services were limited to the parts of Petitioner's body that were injured as a result of the accident and were limited in duration.

2. Dr. Ari Kaz testified that the services were reasonable and necessary. PX 9 and 19-20. He did question some of the prior treatment for foot injuries.

Respondent stipulated that it did not pay for any of these services.

Respondent objected to Dr. Kaz's bill on the basis that Dr. Kaz was beyond Petitioner's choice of two physicians. T2 at 92-93, 95. The Arbitrator finds Dr. Kaz was not beyond the choices under the two doctor rule.

Petitioner's first physician choice by actual name, may be Dr. Mallios. However even though Petitioner decided to see this personal physician, the worker was given advice by the doctor at Ingalls Occupational Health, the company clinic, that he can see a doctor of his choosing. Thus, choosing to treat by his family doctor is not ipso facto the first choice under the so called two doctor (and chain) rule. He treated Petitioner for two months and then Dr. Mallios recommended that he see a specialist, saying there was nothing more he could do for him, The advice by the agent of the company at Ingalls is not hearsay. Moreover, a patient may testify as to prescriptive advice as well.

Next, Petitioner then saw a foot and ankle specialist, Dr. Burgess. T1 at 19-20. The Commission has repeatedly held that a non-specialist physician's recommendation that the claimant see an unnamed specialist is a referral under Section 8(a). See Maria L. Davis v. Baskin Clothing Co., 95 IIC 796, Emil Trimarco v. ANR Freight Systems, Inc., 94 IIC 377, and David A. Tanner v. Brighton Painting Co., 93 IIC 764. Therefore, the Arbitrator finds that Dr. Burgess was a referral from Dr. Mallios and that Dr. Kaz was at most Petitioner's second physician choice, not his third. The Arbitrator inconclusion finds Dr. Kaz is actually the first doctor seeing the firefighter out of first referral chain.

In summary, notwithstanding the above, if in fact the Commission sustains my finding that the authorization by the Ingalls company clinic (housed in the same facility as the Ingalls Urgent/Emergency Care) to see a doctor of his own choice is actually a referral (to Dr. Mallios) then Dr. Avi Jacob Kaz of Illinois Bone and Joint Institute is under the law, the Petitioner's actual first choice of doctor under the "two doctor" rule.

Either way, 1) if Dr. Mallios is his first choice , or 2) given the interpretation that the company's occupational health doctor advised the patient he could see his own doctor is also a referral from the company doctor - there is no exceeding the choice of doctor rule.

Issue K: Prospective Medical Treatment

Dr. Ari Kaz of Illinois Bone and Joint Institute has recommended arthroscopic right ankle surgery to include evaluation of the ankle joint for instability, removal of the distal tibia osteophyte and ligament reconstruction to address the ATF ligament tear. PX 9.

The Arbitrator finds that this surgery is reasonable, necessary and causally related to the accident. *The Arbitrator orders the Respondent at bar to issue written authorization for said surgery along with all reasonable pre and post surgical testing and care.*

Based upon the totality of the evidence, the Arbitrator finds as a matter of law & a conclusion of fact that under 8(a) this firefighter/Petitioner is entitled to prospective treatment as medically ordered by Dr. Kaz of IBJI plus Respondent is so ordered to authorize the same in writing for surgery and reasonable pre and post surgical care.

This finding and 8(a) Order for Prospective Treatment is supported by the following:

1. Petitioner's right ankle pain has been treated with various conservative modalities, including manipulation, acupuncture, trigger point therapy, physical therapy and work conditioning. Nevertheless, the pain has not gone away. In fact, as evidenced by both Petitioner's testimony and the April 15, 2015 report of the Athletico physical therapist, when Petitioner attempted to perform simulated firefighter/paramedic work activities during work conditioning, the pain got worse, and the therapist recommended that the work conditioning be stopped. T1 at 23 – 25, T2 at 67-70, PX 4.

2. The surgery recommended by Dr. Kaz was also recommended by Petitioner's previous treater, Dr. Brian Burgess. PX 3.

3. Dr. Arman Kelikian, Respondent's examining physician, conceded that it was not unreasonable for Dr. Burgess (and by extension Dr. Kaz) to recommend arthroscopic ankle surgery. RX 11 at 54-55. (emphasis added)
4.

Issue L: Temporary Benefits

TTD

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and conclusion of fact that Petitioner is entitled to temporary total disability benefits for the 36 1/7 week period from November 9, 2014, the day after the accident, through July 19, 2015. This finding is supported inter alia by the following:

1. Petitioner's first two treating doctors, Dr. Nick Mallios and Dr. Brian Burges, expressed the opinion that he was unable to work while he was under their care, PX 2 and 3, his third treater, Dr. Ari Kaz, expressed the opinion that he has been unable to work as a firefighter/paramedic at any time since the accident. PX 9 at 17.

2. Petitioner was given a light duty release at Ingalls Occupational Health on November 10, 2014. PX 1. However, Petitioner testified that light duty was not made available by Respondent until July 19, 2015, at which point he obtained a light duty release from Dr. Burgess and returned to light duty. T1 at 27-28, PX 3.

TPD

Based upon the totality of the evidence, the Arbitrator finds that Petitioner is entitled to temporary partial disability benefits for the 32 4/7 week period from August 7, 2015, when he started working a reduced light duty schedule of 15 hours per week, through March 21, 2016, the date of the last hearing. This finding is supported inter alia by the following:

1. Petitioner testified that he returned to light duty work on a 40 hour per week schedule on July 20, 2015; that even though the work he was assigned was office work, it required a significant amount of walking; that over the next two weeks the walking aggravated his ankle pain to the point where he had to start using crutches again; that he was then restricted by Dr. Burgess to 15 hours per week; and that he has been doing the same office work on this reduced 15 hour per week schedule since August 7, 2015. T 1 at 27-30, 97-98, 111-112, PX 3.

2. When Petitioner saw Dr. Kaz on August 18, 2015, Dr. Kaz told him to continue light duty, T1 AT 31. Since he did not specifically indicate how many hours Petitioner should work, it is reasonable to infer that he thought Petitioner should continue working under the 15 hour restriction that Dr. Burgess had given him.

Issue M: Credit

TTD

The parties stipulated that Respondent paid Petitioner his regular salary for the 23 week period from November 9, 2014 through April 17, 2015 and that these salary payments totaled $36,360.78. Under Section 8(j)(2), an employer is entitled to credit for salary payments only to the extent of its TTD liability. Elgin Board of Education v. Illinois Workers' Compensation Commission, 409 Ill.App.3d 943, 954 (1st Dist.2011); Caroline Tamburrino v. Village of Oak Park, 99 IIC 370.

Therefore, based upon the totality of the evidence, the Arbitrator finds as a mtter of law and conclusion of fact, that Respondent is entitled to a credit of $24,240.52 ($36,360.78 x 2/3) for TTD. Any salary continuation under plan or not, paid above the TTD rate cannot be swept so to speak into credit against other benefits due as TPD or PPD.

TPD

The parties stipulated that Respondent paid Petitioner $19,366.97 ($594.60 per

week) for his part-time light duty work for the 32 4/7 week period from August 7, 2015 through March 21, 2016. The Arbitrator finds that Respondent is not entitled to a credit for these payments, since they merely establish the basis for the calculation of Petitioner's TPD benefit of $660.67 per week ($1,585.60 - $594.60 = $991.00 x 2/3 = $660.67).

Additional payment of Benefits

The parties stipulated that Respondent paid Petitioner an advance of $3,000.00. The Arbitrator finds that Respondent is entitled to a credit for this payment.

Issue O: Other Issues

Petitioner Exhibit seven is admitted. Petitioner Exhibit 8 is rejected. Petitioner Exhibit 19 is rejected. See infra for findings and conclusions.

Issue N: Penalties

An opinion from an IME doctor does not automatically insulate a respondent from an award of penalties and attorney's fees. See, e.g., Jeffrey L. Backenger v. Wal-Mart Stores, Inc., 15 IWCC 396; Nanci Norris-Przydia v. The DeLong Co., Inc., 14 IWCC 319; Linette Bailey v. HCR Manor, 14 IWCC 607. Indeed, a respondent which has denied liability is only entitled to protection from a penalties award if its reliance on the IME doctor's opinion is reasonable under the circumstances. Backenger, id.

In this case, as shown by the letter that Respondent's counsel sent to Petitioner's counsel on April 17, 2015, PX 20, Exhibit C to Petition for Penalties and Attorney's Fees, Respondent's denial of Petitioner's claim was based on the opinion of Dr. Arman Kelikian that there was "no known accident" and "no real injury". Respondent's reliance on this opinion was unreasonable inter alia for the following reasons:

1. At the time of its denial of Petitioner's claim, Respondent was in possession of overwhelming and undisputed evidence that Petitioner had an accident at work on November 8, 2014 (see report from Fire Commander) and that he had sustained a significant injury to his right ankle and foot as a result of the accident, including accident reports from Petitioner and his shift commander, PX 17 and 18, and records of Ingalls Occupational Health and Dr. Nick Mallios. PX 1 and 2. This evidence should have caused Respondent to question in the extreme, of Dr. Kelikian's opinion that Petitioner had not had an accident or sustained an injury. That is the doctor overreaching into a legal issue, or in light most favorable to this highly credentialed doctor, his determination that no traumatic event took place (as an actual basis for finding no causation). In fact, it is quiet a poor reflection on him that he sights

medical records that do not have one itoa of relationship, either temporal or medical, to the case and facts at bar.

2 Moreover, no fire officer was deposed or testified nor was any recorded statement offered to show the body mechanics of the trauma in the work out room either did not occur, or could not based upon the exercise reported or the equipment used.

2. Dr. Kelikian contradicted himself in his reports: on the one hand he indicated that Petitioner had not sustained an injury, but on the other hand he clearly believed that there was enough wrong with Petitioner's foot and ankle that he was not willing to release Petitioner to return to work.

This should have deterred Respondent from relying on Dr. Kelikian's negative opinion regarding the injury.

3. Dr. Kelikian's reports are singularly unimpressive and an embarrassment to our system given his credentials. It is obvious on reading the reports that Dr. Kelikian did not have a clear understanding of the facts of the case; in fact, he had so little understanding of the facts that he confused Petitioner's November 8, 2014 accident and injury with his September 6, 2013 accident and injury. Moreover, the reports are so careless and disorganized that they indicate by reasonable inference , that Dr. Kelikian seem to fail in giving careful thought to their preparation. This too should have deterred Respondent from relying on the opinions stated in the reports.

4 .Dr. Kelikian conceded at his deposition that the April 30, 2015 ultrasound showed thickening of the ATF ligament consistent with a partial tear of the ligament; that an incident in which a person's foot gives way while he is lifting a barbell is capable of causing an ATF ligament tear; that Petitioner complained to him of pain in the area around the ATF ligament at the time of his June 9, 2015 examination; that he himself noted tenderness in that area; that thickening of the ATF ligament can cause lateral impingement. This is one of the conditions that caused both Dr. Burgess and Dr. Ari Kaz of IBJI to recommend surgery; Therefore the recommendation of surgery was not unreasonable. RX 11 at 48-55.

In summation, given the totality of Dr. Kelikian's testimony and documentary evidence, These concessions, misplace reliance on non related records and the reported mechanics of the injury by the firefighter and Commander prove on their own that Respondent's reliance upon Dr. Kekikian in this particular case and set of facts of the doctor's own doing so to speak, was clearly

unreasonable. (emphasis added) This is so despite the extremely aggressive defense of all issues at the multiple hearings. The video was not probative.

Claims management's denial of the case after the IME reports and testimony of Dr. Kelikian brought this case to where it is now. Now that proofs are closed and now that the Respondent has had every opportunity to do 'discovery on the stand" of multiple witnesses this case should be accepted as compensable.

Petitioner's counsel formal request of May 4, 2015 seeking reconsideration of the denial of Petitioner's claim in retrospect in June 2016 was exceptionally on point after studying all the evidence after hours of testimony plus Dr. Kalikian's failed testimony.

Notwithstanding the above, only due to the defense counsel's well prepared, insightful cross examination and probing each and every line of documents et cetera and presentation of her own case in chief did the Respondent show sufficient good faith challenge to the payment of compensation as enunciated in the cases of Avon & Brinkman.

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

Diane Burton,

Petitioner,

vs. NO: 14WC 2500

Security Managment Group,

18IWCC0305

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability, prospective medical, 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 April 17, 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 $7,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 17 2018
o050918
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

BURTON, DIANE
Employee/Petitioner

Case# **14WC002500**

SECURITY MANAGEMENT GROUP
Employer/Respondent

18IWCC0305

On 4/17/2017, 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 0.95% 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:

5040 CUTLER & HULL
DAVID P CUTLER
70 W MADISON ST SUITE 2101
CHICAGO, IL 60602

1139 NOBLE & ASSOCIATES PC
LISA BARBIERI
387 SHUMAN BLVD SUITE 210-E
NAPERVILLE, IL 60563

18IWCC0305

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)

Diane Burton
Employee/Petitioner

v.

Security Management Group
Employer/Respondent

Case # 14 WC 2500

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **March 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **September 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.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to strains and sprains that required conservative care through November 2013. The Arbitrator further finds that Petitioner failed to establish causation as to the need for treatment from January 16, 2014 forward.

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

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

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

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

ORDER

THE ARBITRATOR AWARDS THE FOLLOWING REASONABLE AND NECESSARY MEDICAL EXPENSES, SUBJECT TO THE FEE SCHEDULE: 1) NORTHWESTERN MEMORIAL HOSPITAL, 9/28-9/29/13, $6,854.00 AND 2) NORTHWESTERN MEDICINE, 9/28-9/29/13, $800.00. PET. 103-104.

THE ARBITRATOR AWARDS NO OTHER BENEFITS.

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

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

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

Molly C Mason

Signature of Arbitrator

4/13/17
Date

ICArbDec19(b)

APR 17 2017

Diane Burton v. Security Management Group
14 WC 2500

18IWCC0305

Summary of Disputed Issues

Petitioner, a security guard, claims she injured her neck and back on September 28, 2013, when a co-worker who was operating a golf cart in reverse made contact with her. Petitioner signed out for the day shortly before the accident and was on her cell phone, waiting for a ride, when the accident occurred. She testified she was waiting in an area designated by Respondent. Respondent's witness, the co-worker, testified the cart only "slightly bumped" Petitioner and that Petitioner was still behind the cart after the impact.

Dr. Ghanayem noted symptom magnification when he examined Petitioner on November 3, 2014, at Respondent's request. His history reflects that Petitioner reported being struck "about the waist level and thrown about 10 feet" at the time of the accident. He did not have access to the MRI images on that date. Pet 170. After reviewing those images, and noting "bona fide spinal cord compression" at various levels of the cervical spine, he opined, in a supplemental report, that, given the reported mechanism of injury, Petitioner might have sustained a spinal cord contusion "giving her a sense of dysesthetic-type pain in her arms or legs" or that the symptom magnification could have "masked" the underlying cord compression. He recommended a laminoplasty, "irrespective of issues of causation." Pet 171.

At issue are accident, causation, average weekly wage, temporary total disability from the accident through the hearing of March 20, 2017, medical expenses, prospective cervical and lumbar spine surgery and penalties/fees. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she graduated from high school and attended college for about six months. T. 12. She began working as a security guard for Respondent about a year before the September 28, 2013 accident. T. 14. As of that accident, she also worked for Community Care. Her job at Community Care involved taking care of her mother. At that job, she earned $10.15 per hour and worked 3 hours per day, 5 days per week. T. 13.

Petitioner testified that during the year preceding the accident, she worked for Respondent 8 hours per day, 5 days per week. T. 15. Her schedule varied in terms of start and stop times. Sometimes she worked from 4 to 12. On other occasions she worked from 10 to 10:30 or from 5 to 12. T. 15. She averaged about $875 every two weeks. T. 17.

Petitioner denied injuring her neck or back or having any neck or back problems before the accident. T. 14.

Petitioner testified she worked for Respondent from 2 PM to 10:30 PM on the day of the accident. T. 17. Her job that day involved checking peoples' bags. She signed out from

work after finishing her shift and went to a specific location to wait for her boyfriend, who was coming to pick her up. She testified her supervisor had instructed her to wait for rides at this location. T. 18. Another woman, "Meyer," was waiting at the same spot. T. 21. She and "Meyer" conversed, while sitting down, and then she (Petitioner) stood up and began using her cell phone, with her back turned, to call for a ride.

After looking at a group of photographs marked as Petitioner Group Exhibit 1, Petitioner testified that the first photograph in this group shows her standing near the entrance of the building near where the accident occurred. She testified that the building façade did not look the same at the time of the accident because it did not have the doorway shown in the photograph. In the photograph, she is standing in the same location she was standing before the accident. T. 20-21.

Petitioner testified that, immediately before the accident, she heard "Meyer" say "stop" four times. She looked around and saw a golf cart that was moving in reverse toward her. A man and a woman were in the golf cart. The woman was driving. The golf cart continued moving. The back of the golf cart struck her low back and hips "real hard," causing her to "run" forward 20 to 30 feet. T. 21-25. Petitioner testified that the third photograph in Petitioner Group Exhibit 1 shows the sidewalk she "ran" down after being struck. The sidewalk slanted down. She was running downhill in order to keep her balance and avoid falling. T. 25. She managed to catch herself and not fall to the ground because she was wearing a backpack that had a jar inside it. T. 25. When she came to a stop, she leaned over and "jerked", with her hands near the ground. Her neck hurt. T. 25-26.

Petitioner testified that, at this point, she head the female driver of the golf cart get on a phone and call Mark, a supervisor. She heard the driver tell Mark that "she was just driving backwards and made a mistake and hit [Petitioner] real hard." T. 27.

Petitioner testified that Mark then called her and told her she had to "go to the ambulance." She told Mark her friend was coming to pick her up and he could take her to the hospital. T. 28. Mark again directed her to go via ambulance. T. 28. He then asked her if she was doing this for the money. She told him she was "hurting real bad" and money had nothing to do with it. T. 29. Mark directed her to go make a report. She re-entered the building and "made [her] report" to a female supervisor who was sitting inside the building. T. 30. She complained about headaches as well as pain in her neck, back and hips. T. 31.

Petitioner testified the golf cart struck her in the low back and hips. She developed bruises in that area where she was struck. Personnel at the Emergency Room observed these bruises. T. 31.

Petitioner testified the ambulance transported her to the Emergency Room at Northwestern Memorial Hospital. She further testified she complained of headaches as well as pain in her low back, hips and neck at the Emergency Room. Hospital personnel did not prescribe any medication for her. T. 32-33.

The Emergency Room triage records of September 28, 2013 reflect that Petitioner reported being "backed up on by golf cart." A triage nurse noted that Petitioner denied falling or losing consciousness. She further noted that Petitioner complained of headaches.

An Emergency Room physician, Dr. Kaylor, did not describe any bruising or skin abnormalities. On examination, he noted no pain with active neck range of motion and tenderness to palpation "over entire thoracic and lumbar spine without step-offs." He described Petitioner's abdomen as distended due to a "known uterine fibroid." He ordered blood work and various radiographic studies, including chest, spinal and pelvic X-rays and CT scans of the brain and cervical spine. The thoracic and lumbar spine X-rays showed mild osteophytes and spurring at various levels and no acute fractures. The pelvic X-rays showed no acute fracture. The brain CT scan, performed without contrast, showed no acute intracranial process. Pet. 181. Petitioner was discharged from the Emergency Room at about 2 AM on September 29, 2013, with Dr. Kaylor noting she was "able to ambulate w/o assistance." Pet. 165.

Petitioner testified she returned to Northwestern Memorial Hospital the following day in order to correct the name that appeared on her medical records. T. 32-33. A note in the hospital records reflects Petitioner "returned to ED" on September 29, 2013 because the discharge instructions she had received "were in different pt name." Emergency Room personnel gave Petitioner corrected records and a prescription for Motrin and Norco. Pet. 166, 357.

Petitioner testified she returned to work and passed a required drug test. T. 33. She saw a physician at Occupational Health Care, at Respondent's direction. This physician prescribed physical therapy. She testified the providers at Occupational Health Care observed the bruising on her low back and hip. T. 34, 35-36. They told her she had a fibroid tumor but she was already aware of this. She had this tumor before she began working for Respondent. T. 35.

The records from Occupational Health Centers of Illinois reflect that Petitioner saw a physician's assistant, Gia Ellason [hereafter "Ellason"], on September 30, 2013. Ellason recorded the following history:

> "Pt states that while at work on 9/28/13 a co-worker of hers ran into her with a golf cart, striking her in the back. The pt reports that she experienced immediate pain thereafter."

Ellason noted complaints of neck soreness and stiffness as well as 8/10 lower thoracic and lumbar pain. Ellason indicated that Petitioner had received a prescription for pain medication at an Emergency Room but had not yet filled this prescription.

Ellason described Petitioner's gait as normal but slow. She noted no ecchymoses. On cervical spine examination, she noted a full range of motion with pain rotating right. She also noted moderate tenderness to palpation of the lower thoracic spine and lumbar spine. She ordered lumbar spine X-rays which were negative on preliminary reading. She diagnosed cervical and low back strains and thoracic and lumbar contusions. She prescribed Ibuprofen and Tramadol and directed Petitioner to start therapy. She released Petitioner to primarily seated work with no bending. Pet 31.

Petitioner testified that, at some point after the accident, she worked for one week. During that week, Respondent provided her with clerical work which she performed while sitting at a table. If she tried to stand up, because she could no longer tolerate sitting, a supervisor would "start hollering at her." She told the supervisor her neck and back were hurting. At the end of the week, she "told them [she] was hurting too bad" to continue. T. 37-38.

Petitioner continued treatment at Occupational Health Centers during this time. She began a course of physical therapy at the same facility on October 7, 2013. On that date, Ellason provided a lumbar brace to her and continued the previous restrictions. Pet 34-35.

On November 1, 2013, Ellason noted persistent lumbar pain, rated 6/10, but indicated that Petitioner described herself as "60% better." On re-examination, Ellason noted a full and painless range of cervical spine motion, mild tenderness to palpation of the lumbar spine and negative straight leg raising. She revised work status so as to restrict Petitioner to sitting 60% of the time and referred Petitioner to a physiatrist. Pet. 40-41.

Petitioner returned to Occupational Health Centers on November 15, 2013 and again saw Ellason. Ellason noted that Petitioner continued to complain of intermittent lumbar pain and had plateaued in physical therapy. Ellason also noted that Petitioner's claim was now "under investigation" and that Petitioner had not yet secured approval to see a physiatrist.

Ellason described Petitioner's gait as normal. On re-examination, she noted a full range of cervical spine motion with no tenderness, negative Spurling's, no thoracic tenderness, mild tenderness to palpation of the lumbar spine, a decreased range of lumbar spine motion and negative bilateral leg raising to 80 degrees. She released Petitioner to modified work, sitting 60% of the time and bending no more than twice per hour. She noted the previous referral to a physiatrist and advised Petitioner to see "a personal physician in the event that symptoms continue." Pet. 43.

Petitioner testified that, on a Friday, the occupational clinic told her to begin seeing her own doctor and released her to work. At that point, she contacted her primary care doctor but was told the next available appointment was in six months. The following Monday, she went to a pain clinic and began seeing Dr. Levy, a chiropractor.

There are no records in evidence indicating Petitioner underwent care between November 15, 2013 and January 16, 2014.

Petitioner began a course of care at Bridgeport Pain Control on January 16, 2014. She completed an "accident injury history form" on that date. On this form, she described the mechanism of the work accident as follows:

> "I got hit [in] the back by a golf car[t]. I almost fell but I caught myself."

Petitioner also indicated her "head was spun" due to the impact. She complained of constant back pain and neck pain and stiffness. She also complained of dizziness and blurred vision. Pet. 276-278.

Petitioner saw Dr. Osman, a neurologist affiliated with Bridgeport Pain Control, on January 16, 2014. In his note of that date, Dr. Osman acknowledged a referral from Dr. Levy. He described Petitioner as a security guard "who was hit on her back by a golf cart on 9/28/13, causing low back pain." He described this pain as radiating to the thighs and knees. He did not note any other complaints. On lumbar spine examination, he noted spasm, a limited range of motion (worse on the right) and positive straight leg raising at 65 degrees on the right and 70 degrees on the left. He diagnosed a lumbar sprain/strain and radiculopathy, "all probably due to the" work accident. He prescribed Tramadol and Flexeril and concurred with the need for therapy and chiropractic care. He indicated he would consider performing an EMG if Petitioner failed to improve in 2 to 3 weeks. Pet. 164.

In an addendum issued the same day, Dr. Osman noted that Petitioner was also complaining of neck pain radiating to her head and right arm. He indicated his cervical spine examination showed spasm, tenderness and limited motion. He added diagnoses of cervical sprain/strain and radiculopathy. Pet. 165.

Petitioner filed an Application for Adjustment of Claim on January 24, 2014, alleging a low back injury of September 26, 2013. The handwritten date "10-3-13" appears next to Petitioner's signature.

Dr. Levy, a chiropractor affiliated with Bridgeport Pain Control, evaluated Petitioner on January 29, 2014. He described Petitioner as having been struck in the back by a golf cart while at work. He noted complaints of low back pain, pain radiating into both legs, neck pain and headaches. After examining Petitioner and noting multiple abnormalities, he diagnosed acute cervical and lumbar strains, along with post-concussion syndrome, and referred Petitioner to Dr. Osman for a neurological consultation. He also recommended chiropractic care and directed Petitioner to remain off work. He indicated Petitioner could possibly be ready to return to work "by the end of February." Pet. 273-274.

Petitioner saw Dr. Osman again on February 6, 2014. In his note of that date, he indicated that Petitioner reported developing left ear ringing and headache "a week ago." He indicated Petitioner denied head trauma. On re-examination, he noted positive straight leg raising on the right at 70 degrees and on the left at 80 degrees. He described Petitioner's reflexes as "generally decreased." He diagnosed a lumbar strain/sprain and radiculopathy, "all probably due to" the work accident. He prescribed Tramadol and Flexeril and concurred with the need for therapy and chiropractic care. He performed lower extremity EMG/NCV testing. He described this study as "compatible with right L4-L5-S1 radiculopathy." Pet. 149-150.

On February 14, 2014, Dr. Garcia, a chiropractor affiliated with Bridgeport Pain Control, noted ongoing neck and low back symptoms. He linked these symptoms to the work accident and found Petitioner unable to work. Pet. 271-272.

At Dr. Levy's recommendation, Petitioner underwent a lumbar spine MRI on February 27, 2014. Dr. Kuritza interpreted this study as showing a 5-6 millimeter posterior disc herniation at L5-S1 with an extruded nucleus pulposus and associated stenosis. He also noted a large pelvic mass in the region of the uterus for which he recommended further work-up. Pet. 156, 207.

At Dr. Levy's referral, Dr. Jain evaluated Petitioner on March 18, 2014. In his note of that date, the doctor recorded the following history:

> "The patient is a 52-year-old female who was injured on September 28, 2013. She was hit from the back by a golf cart at Millennium Park while working."

Dr. Jain indicated that Petitioner denied having any pre-accident history of neck or back pain.

Dr. Jain described Petitioner's gait as antalgic. He described straight leg raising as positive bilaterally. He interpreted the lumbar spine MRI as showing a 5 to 6 millimeter disc herniation at L5-S1 with extruded nucleus. He recommended bilateral L5-S1 and S1 transforaminal injections, along with continued therapy and a cervical spine MRI. Pet. 167-168, 239-241.

On April 5, 2014, Dr. Jain administered bilateral L5-S1 and S1 transforaminal epidural steroid injections. Pet. 242-243.

Dr. Osman performed repeat EMG/NCV testing on April 10, 2014. He noted complaints of low back and neck pain radiating to the head, along with weakness of the thighs, knees and right arm. He interpreted the EMG/NCV as compatible with right C5-C6-C7 radiculopathy. He also noted an incidental finding of mild right carpal tunnel syndrome. Pet. 336-337.

Petitioner saw Dr. Jain again on April 14, 2014, with the doctor noting some improvement in back and leg pain secondary to the April 5th injections. The doctor noted that

Petitioner was still complaining of neck and right arm pain. On examination, the doctor noted positive straight leg raising bilaterally. He found Petitioner's symptoms to be directly related to the work injury. He recommended lumbar facet injections and indicated he was awaiting the results of a cervical spine MRI. Pet. 244-245.

Dr. Jain administered bilateral L3-L4, L5-L5 and L5-S1 facet injections on April 28, 2014. Pet. 145-152, 230-231, 246-247.

Petitioner underwent the previously recommended cervical spine MRI on April 30, 2014. Dr. Kuritza interpreted this study as showing posterior herniations at C4-C5, C5-C6 and C6-C7 with spinal stenosis and bilateral neuroforaminal narrowing seen, which appeared slightly greater on the left at the C6-C7 level. Pet. 208, 315.

In early May 2014, Petitioner was hospitalized secondary to uterine fibroid surgery. Pet. 217, 302.

On May 12, 2014, Dr. Jain noted the results of the cervical spine MRI. He also noted that Petitioner complained of neck and head pain with bilateral arm numbness, worse on the right. He indicated that Petitioner was off work and taking Tramadol per Dr. Levy. He recommended cervical epidural steroid injections. He again related Petitioner's symptoms to the work accident. Pet. 248-249.

A therapy note dated June 4, 2014 describes Petitioner as walking in a guarded fashion while using a cane. Pet. 283.

On June 9, 2014, Dr. Jain described Petitioner's pain as "unchanged." He recommended additional cervical injections and bilateral medial branch blocks at L3 through S1. Pet. 250-251.

A therapy note dated July 11, 2014 describes Petitioner as walking slowly and using a cane. Pet. 284.

On July 31, 2014, Dr. Osman prescribed Tramadol and Flexeril and recommended ongoing therapy. Pet. 203.

On August 22, 2014, Dr. Garcia issued a report addressing causation. With respect to the work accident, he indicated a large stainless steel golf cart, moving in reverse, struck Petitioner on the back of her right lower lumbar spine while Petitioner was talking on a cell phone. He indicated that, "due to the force and weight of the impact, [Petitioner] apparently forced her back and neck into a hyperextended position, where she reportedly felt a popping sensation in her neck and then, from the weight of the vehicle, was thrown forward." He went on to say that Petitioner "attempted to run to catch herself from falling forward from the impact several feet" and experienced an immediate onset of headaches and pain in her neck, mid-back and low back. He opined that the accident caused a "severe, whiplash-type injury" that resulted in cervical and lumbar disc herniations. Pet. 268.

On August 25, 2014, Dr. Jain noted ongoing neck and low back complaints. He recommended a cervical epidural steroid injection, bilateral lumbar medial branch blocks and continued therapy with Dr. Levy. Pet. 253.

Dr. Michael, a neurosurgeon, evaluated Petitioner on September 10, 2014. The Arbitrator notes that only the second page of Dr. Michael's September 10, 2014 is in evidence. The history section is missing. The second page reflects a preliminary diagnosis of "non-specific cervical and lumbar radiculitis." It also reflects the doctor asked Petitioner to retrieve her MRIs and return in two weeks. PX 322.

On September 22, 2014, Dr. Jain administered cervical epidural steroid injections at C7-T1. Pet. 234-235, 254-255.

On October 6, 2014, Dr. Jain administered medial branch blocks and facet joint injections. Pet. 228-229, 256-257.

On October 20, 2014, Dr. Jain administered additional medial branch blocks and facet injections. Pet. 226-227, 258-259. He also prescribed a "Game Ready" pneumatic compressor system. PX 3.

On October 27, 2014, Dr. Jain noted that Petitioner's low back pain had improved but that she was still experiencing significant neck pain. He recommended radiofrequency ablation. Pet. 260-261.

At Respondent's request, Petitioner saw Dr. Ghanayem for purposes of a Section 12 examination on November 3, 2014. The doctor recorded the following history in his examination report:

> "Ms. Burton is a 52-year-old lady who used to work for a security company at Millenium Park. She states on September 28, 2013, she was standing with her back toward a golf cart-type vehicle that then started up and backed into her. She states it hit her about the waist level and she was thrown about 10 feet but she did not fall to the ground. She states she felt a snap in her neck and also had pain in her back where she was hit. She has ongoing neck pain with circumferential bilateral arm pain. She also has low back pain at the lumbar base with circumferential anterior and posterior thigh and leg pain. She has been involved in physical therapy since January of this year. She does not think she was in therapy before that. She stopped working in November of last year. She has had some injections in her cervical and lumbar regions."

Petitioner testified that, when Dr. Ghanayem asked her how far she traveled after getting struck, she told him she did not know and that it might have been "10, 20, 30 feet." T. 43.

Dr. Ghanayem described Petitioner's posture and gait as normal. On cervical and lumbar spine examination, he noted "multiple areas of soft tissue tenderness to light single finger palpation" that was "associated with some gyrating motions." He also noted several positive Waddell's findings. He indicated that when he tested Petitioner's upper extremity reflexes, Petitioner's arms jerked "in a manner not consistent with any known reflex pattern." He noted "breakaway weakness in all motor groups tested in the upper extremities" and on lower extremity neurologic exam. He described tension signs as "negative for radicular pain."

Dr. Ghanayem indicated he reviewed certain unspecified records along with reports concerning cervical and lumbar spine MRIs. He stated he had not been provided with the actual MRI images. He expressed concern about the non-organic findings and symptom magnification but expressed a desire to see the MRI images. He addressed causation as follows:

> "Her mechanism of injury in context with what I see clinically would lead me to believe that she sustained nothing more than a cervical and lumbar strain."

He found it "most likely" that Petitioner "did reach MMI in October of last year, as indicated by Dr. [sic] Ellason." He addressed treatment needs and work capacity as follows:

> "Unless there is something dramatically wrong on her MRI scan (which I cannot imagine, given the physical exam findings), this patient should be returned to work at regular duty and requires no further medical care. The use of multiple injections has not been medically reasonable for the subjective complaints that this patient exhibits, as well as her physical exam findings."

Pet. 170.

On December 17, 2014, Dr. Michael noted ongoing complaints of severe, radiating low back pain and neck and bilateral arm pain, worse on the right. He indicated he had not been able to review the previous MRI studies and that these studies were now almost one year old. He recommended that Petitioner undergo new lumbar and cervical spine MRI scans. Pet. 323.

Petitioner underwent the repeat MRIs on December 22, 2014. Dr. Lutz interpreted these MRIs. He described the cervical spine MRI as showing "extensive spondylotic changes throughout the cervical spine" and "disc-osteophyte complexes resulting in varying degrees of

relatively severe stenosis from C4-C5 through C6-C7." He indicated the lumbar spine MRI revealed disc bulging from L3-L4 through L5-S1 and no stenosis. PX 4. Pet. 145-148, 316-319.

On January 14, 2015, Dr. Michael wrote to Dr. Levy, indicating he had reviewed the repeat MRIs. He interpreted the cervical spine MRI as showing "herniated discs at C4-C5, C5-C6 and C6-C7, with resultant central stenosis and increased signal within the cord in the area of C5 and C6." He interpreted the lumbar spine MRI as showing a central disc herniation at L5-S1. He indicated he advised Petitioner she could either live with her pain or opt to undergo surgery, namely an anterior cervical discectomy and fusion and a posterior lumbar fusion. Pet. 324325.

Petitioner returned to Dr. Michael on March 4, 2015. The doctor noted complaints of pain in the neck, both arms, back and both legs along with weakness in the right arm and left leg. He indicated that Petitioner reported one episode of bladder incontinence three weeks earlier. With respect to the neck, he told Petitioner she could either live with the pain or consider undergoing an anterior cervical discectomy and fusion. He indicated Petitioner opted for surgery since she felt unable to live with her pain. He indicated that, while Petitioner also needed a lumbar discogram, he planned to focus initially on the cervical spine. Pet. 166, 326.

On April 3, 2015, Dr. Levy issued an "update report" noting that Petitioner was still experiencing neck and low back pain as well as radicular symptoms in her arms and legs. He also noted Dr. Michael's surgical recommendation. He found a causal relationship between Petitioner's symptoms and the work accident. He further found Petitioner to be "permanently totally incapacitated for all work." He indicated Petitioner was awaiting a second surgical opinion. Pet. 264-265.

On August 14, 2015, Dr. Ghanayem issued an addendum, after reviewing cervical and lumbar spine MRI images. [He did not specify the dates of these images.] He interpreted the lumbar spine MRI as showing "just a minor degree of disc degeneration without any neurologic compression." He indicated he stood by his original report, insofar as the lumbar spine was concerned, and believed the accident caused nothing more than a lumbar strain.

Dr. Ghanayem went on to address Petitioner's cervical spine. He indicated he was "a bit surprised" by the cervical MRI scan since it showed "bona fide spinal cord compression with cervical spondylosis and what appears to be disc disease" at several levels. He opined that, "given [the] mechanism of injury, [Petitioner] may have sustained a spinal cord contusion giving her a sense of dysesthetic-type pain in her arms and legs." Alternatively, he theorized that the symptom magnification he noted at the examination "may have masked underlying bona fide spinal cord compression." He recommended cervical spine surgery, specifically a laminoplasty, "irrespective of issues of causation." He ended his report by stating: "given the mechanism, I do believe that this condition was probably aggravated from her work injury." He did not comment on Petitioner's work capacity. Pet. 171.

Petitioner testified she would like to return to work but feels she cannot do so at the present time due to her neck and back pain. She would like to undergo neck and back surgery.

T. 43-44. At the time of the accident, she was planning to go back to school to learn to be a massage therapist. That has always been her dream. She would not be able to do this now because she cannot bend, due to neck and back pain. T. 45.

Under cross-examination, Petitioner testified she knows Nicole Jackson, the employee who was driving the golf cart at the time of the accident. Another guard, Keith George, was riding in the cart with Jackson. She knows Jackson and George "by name" only. Petitioner acknowledged that, as of the accident, she had finished her shift and was standing near the building entrance, waiting for a ride home. T. 47. She signed out from work just before the accident. T. 47-48. She was on her cell phone, waiting for her ride to arrive, when she was struck. She was in the process of saying goodbye and hanging up at that time. She managed to continue holding her cell phone after the impact. The phone did not hit the ground. The impact did not cause her to fall but she ended up in a bent over position. Her hands and knees never came into contact with the ground. She "ran" a distance of 20 to 30 feet after the impact and ended up in a bent over position. She managed to catch herself. She continued working for one week after the accident. She recalls being examined by Dr. Ghanayem but she does not know whether she told him she "ran" for 10, 20 or 30 feet.

On redirect, Petitioner testified the golf cart struck her "awfully hard." She "ran" after being struck due to the downward pitch of the sidewalk. The running was a kind of stumbling. T. 53. She managed to catch herself because she was wearing gym shoes. When she came to a stop, she was on her tiptoes, bent over. T. 54.

Nicole Jackson testified on behalf of Respondent. Jackson testified she began working for Respondent in March 2008. T. 59. She is still employed by Respondent's successor company. Respondent changed its name. T. 59. She worked for Respondent from 11 PM to 7 AM on the date of the accident. She does not know Petitioner. Before the accident, she was assigned to the task of ferrying security guards to and from their posts. Immediately before the accident, she was driving a golf cart. She put the golf cart in reverse. The cart began making an unusual noise. She shifted into neutral and the noise stopped. The cart started moving backward. She "slammed" on the brakes but the cart continued "slowly sliding downhill." People in the vicinity of the moving cart started moving to the side, to allow the cart to pass. The cart "bumped" Petitioner, who was standing with her back to the cart, talking on her cell phone. After being bumped, Petitioner turned around but was still on her phone.

Jackson testified she got out of the cart and asked Petitioner if she was okay. Petitioner was "right behind the cart" at this time. Petitioner replied, "hell no, I'm not fucking okay – I got hit." Jackson testified she informed her manager "Mark" of the incident. At his direction, she offered to call an ambulance for Petitioner. Petitioner declined this offer. She then completed an accident report. She identified RX 1 as the two-page report she completed immediately after talking with her manager and supervisor. She testified this report does not contain every detail concerning the incident.

In the report, Jackson described the accident as occurring at about 10:38 PM on Saturday, September 28, 2013. She indicated she was "working as a break person" at that time, ferrying a guard, Keith George, to his post via a golf cart. She described the impact and aftermath as follows:

> "I put the golf cart in reverse, while looking back. I suddenly hit the brakes because I saw Ms. Burton behind me on her phone in the driveway with her back facing me. The cart still bump[ed] Ms. Burton slightly. I turn[ed] off the vehicle and jump[ed] out and ask[ed] her "were she OK." She replied, 'no, I'm not fucking OK.' I asked 'do u need for me to call an ambulance and that I was sorry.' While still on her phone she replied, 'no, my husband is here . . . I'm about to go home' and that he was going to take her to [the] hospital but she wanted to make an incident report. That's when I went to the supervisor, Ms. Brown along with Ms. Burton. . . ."

Jackson further indicated that she and Petitioner told "Mark" what had happened and that Petitioner, after initially declining, eventually accepted Mark's offer to call an ambulance. RX 1.

Under cross-examination, Jackson testified the golf cart bumped Petitioner below the level of the buttocks but not hard enough to cause bruising. The cart did not strike Petitioner's back. T. 68. Petitioner remained on the phone after being struck. She heard Petitioner say "babe, guess what?" She asked Petitioner if she required an ambulance and Petitioner said "no, my husband is coming to pick me up." She never met Petitioner's husband. She apologized to Petitioner for bumping her but not because she felt like she had done a bad thing. T. 69.

Arbitrator's Credibility Assessment

Petitioner's chronology as to her treatment is completely at odds with the records in evidence. Petitioner testified that, on an unspecified Friday, personnel at Occupational Health told her to follow up with her own physician. She further testified she contacted her own physician but was told she could not be seen for six months. The following Monday, she began seeing Dr. Levy, a chiropractor. The records show Petitioner last went to Occupational Health on November 15, 2013 and did not resume care until January 16, 2014.

Respondent's examiner, Dr. Ghanayem, noted symptom magnification and positive Waddell's signs on November 3, 2014. He did not have access to Petitioner's MRI images on that date. After he reviewed those images, he indicated that Petitioner's behavior at the time of the examination "might have masked" the cervical spine pathology evident on MRI. He agreed with the need for cervical spine surgery but based all of his opinions on the assumption

that Petitioner was struck with sufficient force to cause her to be thrown a distance of ten feet. [See further below].

None of Petitioner's treating physicians specifically noted symptom magnification. Dr. Osman, however, noted that Petitioner complained of headaches on February 6, 2014 but denied head trauma.

While the parties disagree on many issues, there is no dispute that a moving golf cart struck Petitioner's back on the night of September 28, 2013, after Petitioner had finished her shift and signed out. Petitioner testified she was waiting for a ride, in an area designated by Respondent, at the time of impact. Nicole Jackson, Respondent's sole witness, did not contradict Petitioner's testimony on this issue. Jackson also acknowledged that the path the cart was moving along sloped downward. She described the golf cart as continuing to "slide" after she changed gears.

Petitioner and Jackson described the force of the impact in quite different terms. Petitioner claimed the cart struck her "awfully hard" while Jackson maintained she was moving slowly and merely "bumped" Petitioner. Petitioner testified the impact and slope caused her to "run" forward a distance of twenty to thirty feet, at which point she came to a stop in a bent over position. Jackson disputed this, indicated she observed Petitioner "right behind" the cart after the impact.

The Arbitrator has weighed the accounts offered by Petitioner and Jackson. The Arbitrator acknowledges that Jackson had reason to be concerned about the accident, given her role as a driver. Overall, however, the Arbitrator finds Jackson more credible than Petitioner with respect to the force of the contact. The Arbitrator finds it troubling that Petitioner would testify, under oath, that the impact caused her to "run" forward 20 to 30 feet and then say, under cross-examination, that she told Dr. Ghanayem she was unsure of the distance and might have traveled 10, 20 or 30 feet. The Arbitrator also finds it troubling that Petitioner claimed to have been hit "awfully hard" yet somehow managed to maintain a grip on her cell phone as she traveled forward. Finally, the Arbitrator notes that the first history in the medical records to mention Petitioner being pushed forward is that recorded by Dr. Garcia on August 22, 2014, almost a year after the accident. Even then Dr. Garcia indicated Petitioner moved forward "a few feet."

Having observed the two witnesses, the Arbitrator concludes the truth lies somewhere in the middle, i.e., that the impact was more than a tap but not forceful enough to propel Petitioner forward.

Arbitrator's Conclusions of Law

<u>Did Petitioner sustain an accident arising out of and in the course of her employment on September 28, 2013?</u>

The Arbitrator finds that the accident of September 28, 2013 arose out of and in the course of Petitioner's employment. In so finding, the Arbitrator relies on the following: 1) Petitioner's unrebutted testimony that the accident occurred shortly after she signed out for the night and while she was waiting for a ride in an area designated by Respondent; 2) Nicole Jackson's written statement, which reflects the accident occurred at 10:38 PM, eight minutes after Petitioner's shift ended; and 3) Nicole Jackson's admission that, immediately before the accident, she was performing a work-related and potentially hazardous task, i.e., operating a golf cart in reverse on a downward sloping path while transporting another guard to his station.

The phrase "in the course of" refers to the time, place and circumstances under which an accident occurs. It has long been held that an accident occurring within a reasonable period before or after the actual work shift is within the course of employment. See Christman v. Industrial Commission, 159 Ill.App.3d 479 (3rd Dist. 1987). Jackson's written report and Petitioner's testimony establish that the accident occurred eight minutes after a shift change, during a period when Respondent could reasonably anticipate that Petitioner would be waiting for a ride in a designated area.

An injury "arising out of" the employment may be defined as one which has its origin in some risk so connected with, or incidental to, the employment as to create a causal connection between the employment and the injury. While it is clear Petitioner was not working at the time of the accident, a condition of her employment, i.e., that she wait for a ride in an area where she could encounter a co-worker operating a golf cart in reverse during a change of guards, exposed her to a risk of injury. See Melvin v. First Methodist Church, 103 Ill.App.2d 465 (1st Dist. 1968). A member of the public could have been exposed to the same risk but would not have been subject to the same condition.

Did Petitioner establish a causal connection between the accident and her claimed current conditions of ill-being?

The Arbitrator finds that Petitioner established causation as to sprains and strains that required a course of conservative care through November 2013. The Arbitrator further finds that Petitioner failed to establish causation as to the need for any care rendered on or after January 16, 2014.

In so finding, the Arbitrator relies primarily on the histories set forth in the initial records from Northwestern Memorial Hospital and Occupational Health Centers. These histories document an impact but say nothing about Petitioner being "thrown" forward a distance of ten or more feet. The examining providers noted complaints of tenderness but did not document any bruising. When Petitioner last visited Occupational Health Centers, on November 15, 2013, Ellason noted no cervical spine or head complaints and only intermittent, non-radiating low back pain. Ellason recommended that Petitioner follow up with her own physician. Petitioner's testimony that her attempt to arrange this was unsuccessful because she would have had to wait six months to see her own doctor is simply not credible. When Petitioner resumed care, in January 2014, her complaints were significantly more varied and intense. Petitioner did not

testify as to what activities, if any, she engaged in during the months following her last visit to Ellason. In fact, those two months are a "blank," as far as the Arbitrator is concerned. It is unclear, for example, whether Petitioner continued taking care of her mother, at her claimed concurrent employment, during that interval.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims over $130,000 in incurred medical expenses. Pet. 1-133.

The Arbitrator has previously found that Petitioner established causation as to the need for conservative care through November 2013. The Arbitrator finds the initial Emergency Room treatment and subsequent care at Occupational Health Centers to be causally related to the accident as well as reasonable and necessary.

Petitioner does not claim any unpaid bills from Occupational Health Centers. This was a provider of Respondent's selection. Of the numerous bills Petitioner claims, the Arbitrator awards only those from Northwestern Memorial Hospital ($6,854.00, Emergency Room care, 9/28-9/29/13) and Northwestern Medicine ($599.70, physician and radiographic/lab services, 9/28-9/29/13), subject to the fee schedule. Pet. 103-104.

Is Petitioner entitled to temporary total disability benefits?

On the Request for Hearing form, Petitioner claimed 3 ½ years of temporary total disability benefits, from the accident of September 28, 2013 through the hearing of March 20, 2017. Arb Exh 1. On direct examination, however, Petitioner acknowledged that Respondent provided her with seated work at some point after the accident [the exact time frame is not clear] but that she performed this work for only a week before deciding she could no longer tolerate it. T. 37-38, 50. At that point, she told Respondent she "couldn't come back because [she] was hurting too bad." T. 37-38. There is no evidence indicating Respondent declined to provide accommodated duty to Petitioner, per Ellason's restrictions, thereafter. Ellason did not take Petitioner off work at any time prior to Petitioner's final visit of November 15, 2013. Ellason was still imposing restrictions as of that date but there is no evidence Respondent terminated Petitioner while those restrictions were in effect. Rather, it appears Petitioner left voluntarily.

The Arbitrator has previously found that Petitioner established causation as to strains and sprains that required conservative care through November 2013. The Arbitrator declines to award temporary total disability based on the evidence described in the preceding paragraph. The Arbitrator views Petitioner as voluntarily leaving an accommodated job.

Based on the findings as to accident, causation and temporary total disability, the Arbitrator finds it unnecessary to address the remaining disputed issues. The Arbitrator awards no benefits other than the two medical bills relating to the care Petitioner underwent on September 28 and 29, 2013.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD A. LISKA,

Petitioner,

vs. NO: 15 WC 21127

BIMBO BAKERIES USA,

18IWCC0306

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, causal connection, medical expenses and permanent disability and being advised of the facts and law, reverses 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 views the evidence different than the Arbitrator and finds April 1, 2015 is the manifestation date of a repetitive trauma injury. There is evidence in the record the repetitive physical demands of Petitioner's job aggravated and accelerated his pre-existing arthritic and avascular necrosis (AVN) conditions in his left hip, worsening on April 1, 2015 and resulting in surgery in August 2015. The Commission bases these conclusions on the following:

Findings of Fact and Conclusions of Law

Petitioner testified his job duties entailed jumping down from his truck during the years he worked downtown. He testified his first route was downtown Chicago and included Lakeview, Wrigleyville, and up and down Halsted and Clark streets. During those years, working in the crowded city streets, Petitioner testified he could not use the ramp he used in suburban deliveries. In the suburbs he would wheel the stacks down the ramp on a dolly. In the city, he put the stacks at the back of truck, then broke the stack down to about three or four trays at a time. Each tray

weighed approximately twenty pounds. Thus, he carried 60-80 pounds depending on the number of trays he would unload. Then he would jump off the truck, "hitting" (the ground), between 100-200 times per day. (T, p. 45) Petitioner testified he was left-handed and when he jumped off the truck he would normally land on his left leg first. (T, pp. 19, 20)

Petitioner testified he would take the product into the store in a hurry as he was often parked illegally. He testified he jumped from the back of the truck, not the bumper, thus he jumped two or 2-1/2 feet down multiple times each stop for roughly 18 stops per day. (T, p. 16) Eventually his left leg started hurting.

The Petitioner first complained to his primary care physician (PCP) Dr. Malek Akhal at Bolingbrook Family Medicine on April 1, 2015 of leg pain. The History of present illness (HPI) stated, the "problem is fluctuating. It occurs persistently. Location of pain was upper leg and thighs. There was no radiation of pain. Symptoms are aggravated by ascending stairs, bending, changing positions, descending stairs, standing and twisting. ...patient reports one-week history of left lateral hip, inguinal and anterior thigh pain; although he denies a work-related injury, he believes it may be from his physically demanding job..." Clearly Petitioner began to suspect a causal relationship between the physical demands of his job and his symptoms.

On May 5, 2015 the HPI at Bolingbrook Family Medicine documents the onset of pain was gradual. "Context: No injury. He had left quad area pain that subsided. Then he had an insect bite on the left leg that was treated. Now the hip and groin area hurt." The May 5, 2015 initial x-ray and notes state Petitioner's osteoarthritis was mild to moderate.

On May 6, 2015 Petitioner was seen by Dr. Kuhlman. Dr. Kuhlman's comment states specifically "He does not need hip replacement yet. He may have a cortisone injection if he wants. He may also do P.T. to strengthen the hip." Petitioner reported he was in a lot of pain. (Px2)

Dr. Akhal ordered a left hip MRI. The May 20, 2015 MRI results show *inter alia* the findings suggest the presence of osteonecrosis superimposed on arthritic changes. There is bone marrow edema within the left femoral head, suspected to be reactive. Also documented: 1) Findings compatible with osteonecrosis of the left femoral head superimposed on arthritic changes. There appears to be subtle flattening of the articular surface of the left femoral head with underlying sclerosis noted; 2) Mild to moderate narrowing of the right (sic) hip joint; 3) Mild edema with the soft tissues surrounding the left hip with question of mild periosteal edema or reaction along the anterior aspect of the left femoral head and neck junction. The presence of underlying stress injury is difficult to exclude. (Px2)

The Commission finds by virtue of the radiologist's MRI finding, a stress injury was contemplated. Dr. Akhal referred Petitioner to Dr. Domb on May 21, 2015.

As enunciated in *Durand v. Indus. Comm'n* (RLI Ins. Co.) 224 Ill. 2d 53, 72, 862 N.E.2d 918, 929, 308 Ill. Dec. 715, 726, pain and inability to perform one's job and also the medical treatment are factors which can establish the date of injury, significantly when a reasonable person would have plainly recognized the injury and its relation to work:

> In short, courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. See *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 138 Ill. App. 3d 880, 887, 487 N.E.2d 356, 93 Ill. Dec. 689 (1985), *aff'd*, 115 Ill. 2d 524, 505 N.E.2d 1026, 106 Ill. Dec. 235 (1987) (holding that determining the [***29] manifestation date is a question of fact and that "the onset of pain and the inability to perform one's job, are among the facts which may be introduced to establish the date of injury"). A formal diagnosis, of course, 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. See *General Electric Co. v. Industrial Comm'n*, 190 Ill. App. repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. See *Oscar Mayer*, 176 Ill. App. 3d at 610. *Durand v. Indus. Comm'n* (RLI Ins. Co.), 224 Ill. 2d 53, 72, 862 N.E.2d 918, 929, 308 Ill. Dec. 715, 726

The corresponding office notes from Petitioner's first consultation were missing from the certified records from Hinsdale Orthopaedics. (Px3) According to the medical bill, the Petitioner first saw Julie Morgan, the PAC on May 26, 2015.

The first office visit notes from Hinsdale Orthopaedics are from the consultation with the nurse practitioner on August 11, 2015. The hip replacement surgery was performed on August 17, 2015.

Dr. Karlsson's September 3, 2015 §12 opinion report provides insight into Petitioner's first discussion with Dr. Domb. Dr. Karlsson's report states: "On May 10, 2015, he had MRIs of both the back and the hip and the radiologist said that the back was fine, but there was a fracture in the hip. He was referred to Orthopedics and saw Dr. Benjamin Domb at Hinsdale Orthopaedics. He says he was told he would need a hip replacement, and when he told Dr. Domb what he did for work, the patient says Dr. Domb recommended he file with Workers' Compensation. The patient wanted to get his surgery done so he booked it through his regular insurance, and apparently had a hip replacement surgery done August 17, 2015 by Dr. Domb."

The Commission finds that it is patently obvious Dr. Domb reviewed the specifics of Petitioner's job mechanics.

In his September 2, 2015 letter addressed to Dr. Karlsson, Dr. Domb wrote "Mr. Liska is a 48-year-old male patient who had sustained a work-related injury of his hip. He states this started on April 1, 2015. He was working for 14 years as a delivery person, dropping large boxes off at facilities. He was, on April 1, 2015, in downtown Chicago, dropping off 300-400-pound boxes off the back of his truck when he started noticing left hip pain. He had no prior hip injury or hip pain before April 1, 2015. He was diagnosed originally with a strain, and tried a cortisone injection, which gave him no relief. He was diagnosed by MRI of the hip, with avascular necrosis

(AVN) of the femoral head. At that point, the patient was painful enough that the only thing that would help him would be a total hip arthroplasty, anterior approach, which he underwent august 17, 2015."

The Commission notes that Petitioner described the onset of gradual pain at the May 5, 2015 Bolingbrook appointment. Petitioner testified on April 1, 2015 "it was to the point where I was limping, I couldn't even take the pain. …it hurt to walk….in order to get in the truck, I would have to like pull myself. I couldn't sleep. I remember there was times when I was bent over the couch and just screaming." (T, p. 23) By the time Petitioner saw Dr. Domb, he reported his acute pain began April 1, 2015.

The Hinsdale Orthopaedics' records include the Petitioner's questionnaire from May 26, 2015. In response to the question "How did the problem occur?" Petitioner responded, "dropping loads off back of truck." (Px3) The Commission notes the similarity to Dr. Domb's description of Petitioner's job.

Petitioner testified the trays weighed approximately twenty pounds and he would throw three or four trays down off the top of the rack to the bed of the truck, a total of 60-to-70 (sic) pounds at a time. He would then jump down from the bed of the truck 100 to 200 times per day up and down off that truck. (T, pp. 18, 19) He did this at eighteen stops per day and countless stacks were thrown to the ground and piled on the dolly after Petitioner jumped off the bed of the truck. The Commission finds by the end of a day, the total weight could easily be "300-400 pounds" a figure Petitioner and Dr. Domb either discussed at the first consultation, or Dr. Domb extrapolated. The Commission notes Petitioner told Dr. Karlsson "the average load was 200 pounds." (DepT, p. 25) The Commission finds the discrepancy between the terms "boxes" versus "trays' is *de minimus* in this instance.

Dr. Karlsson testified the AVN condition was longstanding and caused the need for hip replacement. He also testified AVN is a condition that comes on idiopathically in this and in 50% of cases and is never caused or aggravated by heavy lifting, jumping or anything other than structural damage (fracture, etc.) or RA, lupus, and other systemic medical conditions. It was his opinion there was no fracture. The Commission finds this does not comport with the MRI; clearly the radiologist did not rule out a stress injury.

Dr. Karlsson also testified there is no known relationship between physical activity and risk for AVN. Dr. Karlsson testified known causes include but are not limited to connective tissue disorders, rheumatologic disorders, heavy steroid use, heavy alcohol use and deep-sea diving. Petitioner has none of these risk factors. Fifty percent or more of such cases are idiopathic. Dr. Karlsson opined Petitioner's condition was completely unrelated to his work duties or activities.

Under the specific hypothetical posed by Petitioner's attorney and comporting with Petitioner's testimony that he jumped up and down from his delivery truck up to 100-200 times-per-day, Dr. Karlsson would not change his opinion that Petitioner's job neither caused nor aggravated his condition, explaining the only thing that would cause an aggravation was "Something that changes the actual structure of the hip. So, if someone were to fall and have the fracture surrounding the hip knock off an osteophyte where you have a loose body floating in the

joint, cause an acute collapse where you have a subchondral fracture and a displaced fragment of the joint, I think certainly things like that could cause a sudden worsening and aggravation and need for earlier treatment." Dr. Karlsson testified he saw no acute changes at all. (DepT, p. 28) This is contrary to the initial radiology report; the radiologist noted "The presence of underlying stress injury is difficult to exclude."

In response to Dr. Karlsson's opinion report, Dr. Domb also wrote a letter to Petitioner's attorney, "We disagree with his findings. It is felt that the patient had been asymptomatic prior to his work-related injury of his hip. He had been working for 14 years as delivery person, dropping off large boxes, 300-400 pounds, off the back of his truck. He had a noted incident on April 1, 2015 where he experienced severe pain in the anterior groin. He had an MRI consistent with avascular necrosis. We do believe that the work injury is causally related to his hip pain."

It is obvious to the Commission the Petitioner's condition was gradually worsening until it became acutely painful on April 1, 2015. The Commission finds Dr. Domb more credible than Dr. Karlsson. The Commission finds Petitioner's left hip condition was aggravated by the Petitioner's jumping 2-1/2 feet to the street off the back of his truck 100-to-200 times per day and jumping back up to the truck bed so he could lift and toss several twenty-pound trays at a time, multiple times at each of his eighteen stops per day, first, off the stacks to the floor of the truck bed, and after jumping off the truck, tossing the trays on to a dolly. Doing this activity everyday over the course of years, clearly aggravated and accelerated both his AVN and arthritic conditions causing him extreme pain on April 1, 2015.

The Commission strikes that portion of the Arbitrator's Decision, under the section Conclusions of Law, from the beginning of the fourth paragraph of that section, to the end of page six. The Commission substitutes the following:

The Commission finds the Petitioner suffered a repetitive trauma injury with a manifestation date of April 1, 2015. Based upon the Commission's finding of accident, and casual connection herein, and the medical records containing the appropriate off work authorizations, the Commission finds Petitioner is entitled to an award of temporary total disability for the period August 27, 2015 through October 25, 2015 at a rate of $753.05 per week for the period of ten weeks, that being the period of temporary total incapacity for work under §8(b).

With regard to the issue of medical expense, the Commission awards Petitioner the outstanding medical bills for the reasonable related medical expenses attendant to the left hip replacement surgery including Hinsdale Orthopaedics in the amount of $35,036.00, ATI Physical Therapy in the amount of $10,983.05, Metro Health in the amount of $2,988.79 and Hinsdale Hospital balance of $1,237.03 as identified in Petitioner's Exhibits numbered three through six, plus Respondent shall pay Petitioner $31,213.14 paid by Local Union 734 representing the negotiated amount of medical expenses under sections 8(a) and 8.2(e) of the Act (820 ILCS 305/8(a), 8.2(e) (West 2006)). The Commission finds "[t]he statute does not require the employer to be a party to the rate agreement in order to receive the benefit of the agreement." *Tower Automotive v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 427, 943 N.E.2d 153, 347 Ill. Dec. 863 (2011)

18IWCC0306

The Commission further finds Respondent is entitled to a credit for related medical bills paid by Respondent's group health insurance carrier, pursuant to Section 8(j), if any, and that Respondent shall hold Petitioner harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit.

Based upon Petitioner's testimony he was able to return to his usual employment, working full-time without restrictions making deliveries, and treating residual symptoms with only over-the counter medications, the Commission finds Petitioner is entitled to an award of 35% loss of use of the left leg under Section 8(e).

IT IS THEREFORE ORDERED BY THE COMMISSION the Decision of the Arbitrator filed June 14, 2017 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay Petitioner temporary total disability benefits for the sum of $753.05 per week for a period of ten weeks, from August 27, 2015 through October 25, 2015 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 $677.75 per week for a period of 75.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 35% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $50,244.87 for outstanding reasonable and necessary medical expenses related to Petitioner's left hip replacement as identified in the following exhibits: Petitioner's Exhibit #3 from Hinsdale Orthopedics, in the amount of $35,036.00; Petitioner's Exhibit #4 from ATI Physical Therapy, in the amount of $10,983.05; Petitioner's Exhibit #5 from Metro Health Solutions, in the amount of $2,988.79; and Petitioner's Exhibit #6 from Hinsdale Hospital, in the outstanding amount of $1,237.03 pursuant to §8(a) and §8.2 of the Act plus Respondent shall pay Petitioner $31,213.14, the negotiated amount of medical expenses under sections 8(a) and 8.2(e) paid by Local Union 734 identified in Petitioner's Exhibit #6.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall get credit for §8(j) if any.

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.

18IWCC0306

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: MAY 16 2018
KWL/bsd
O-03/20/18
42

Thomas J. Tyrrell

Michael J. Brennan

Dissent

I respectfully dissent from the decision of the majority. Arbitrator Thompson-Smith'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 ARBITRATOR DECISION

LISKA, RICHARD A
Employee/Petitioner

Case# **15WC021127**

BIMBO BAKERIES USA
Employer/Respondent

18IWCC0306

On 6/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

1759 MARTAY LAW OFFICE
WILLIAM H MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

5171 KRALOVEC & MARQUARD CHTD
JAMES F DONOVAN
55 W MONROE ST SUITE 100
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

18IWCC0306

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Richard A. Liska
Employee/Petitioner
v.
Bimbo Bakeries USA
Employer/Respondent

Case # **15 WC 21127**

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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **May 17, 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 _____

18IWCC0306

FINDINGS

On the date of accident, **April 1, 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 **48** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$n/a** for TTD, **$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

The Petitioner has not proven by a preponderance of the evidence, that an accident occurred that arose out of and in the course of his employment by Respondent therefore, no benefits are awarded, pursuant to 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.

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) a union lien; 5) temporary total disability; and 6) the nature and extent of Petitioner's injury. *See*, AX1.

Petitioner's testimony

Mr. Richard Liska (the "Petitioner") has been employed by Bimbo Bakeries USA, (the "Respondent"), for approximately ten (10) years as a Route Sales Representative (RSR). The RSR position involves delivery of bread products by truck. Petitioner testified that he would drive to a store, park his truck and bring bread products in racks stacked on a wheeled dolly out of the truck and into the store, usually with the use of a ramp. Petitioner testified that at the time, he was working a downtown route where he could not always use his ramp. When not able to employ a ramp, Petitioner would have to bring trays of bread to the edge of the truck bed, jump down to the ground, load them onto the wheeled dolly then push them into the store. Petitioner testified that he jumped down 2.5 feet off the bed of the truck hundreds of times per day. He admitted upon cross-examination that he could step down off the truck bed onto the bumper then jump to the ground. Tr. pp. 15-38.

On direct examination, Petitioner did not testify to a specific accident occurring at work. He testified that his upper leg and hip area began to hurt on or about April 1, 2015. His application for adjustment of claim references April 1, 2015 as the date of accident. Petitioner further testified that he complained to his primary doctor, Dr. Akhal about an injury at work.

Petitioner's Exhibit 2 contains a record of a doctor's visit on April 1, 2015, when Petitioner was seen by Malek Akhal M.D. Under History of Present Illness, Petitioner told Dr. Akhal that he had upper leg and thigh pain; onset: one week ago. The context is noted as "pulling and twisting movement". "Symptoms are aggravated by ascending stairs, bending, changing positions, descending stairs, standing and twisting".

On May 5, 2015, under History of Present Illness, the note again relates the left leg and hip pain and states that the onset was gradual. "Context: No injury". Left hip x-rays performed that date showed "mild/moderate degenerative changes at the left hip".

On May 20, on Dr. Akhal's order, an MRI of the left hip was performed. The finding was osteonecrosis of the left femoral head superimposed on arthritic changes. Dr. Akhal referred Petitioner to Hinsdale Orthopedics and Dr. Domb on May 21, 2015. On August 11, 2015, Petitioner presented to Dr. Domb, complainiing of left hip pain. Dr. Domb diagnosed osteoarthritis and avascular necrosis of the left hip. Hip replacement surgery was performed by Dr. Domb on August 17, 2015. PX2-3.

Deposition of Dr. Troy Karlsson dated June 27, 2016

Petitioner was seen by Troy Karlsson M.D. for an Independent Medical Examination ("IME") at Respondent's request; and testified by evidence deposition. Respondent's Exhibit 2 which contains his CV, his IME report and his supplemental report as individual exhibits. All were offered as exhibits and admitted without objection.

Dr. Karlsson testified that he attended Northwestern and Columbia University (NY) Medical Schools. His opinions were expressed to a reasonable degree of medical certainty. He testified that the petitioner's medical records, including the MRI of his left hip, established that he suffered from avascular necrosis of the left hip. Dr. Karlsson has regularly treated patients with avascular necrosis (AVN) over a course of over 20 years. Dr. Karlsson performed an IME on the Petitioner on October 8, 2015. Petitioner advised Dr. Karlsson that his left hip had begun to hurt 3 or 4 days prior to his first being seen by a doctor. Petitioner denied any injury from a fall, twist, turn or any traumatic event that brought on his pain. RX1.

Dr. Karlsson testified that avascular necrosis is a condition where there is a loss of blood flow to an area of bone. It develops over years if not decades and that it had developed over a long period in the petitioner. Most sufferers with the petitioner's degree of AVN will eventually feel symptoms without injury. AVN has scientifically-established causes per medical science. Per Dr. Karlsson, whose testimony is unrebutted, heavy work and heavy lifting do not cause AVN. The changes seen on the MRI of the petitioner's left hip were slow-developing and very long-standing changes. RX1, pp. 12-18.

AVN encompassed both sides of the head of the femur; and a majority of the proximal femur was involved. And as Petitioner exhibited no evidence of acute injury, in Dr. Karlsson's opinion, Petitioner's hip condition of AVN was not related to his job. The doctor testified that his opinion is supported by the fact that there were no fractures or other acute injuries. The witness further testified that Petitioner's job activities did not cause the avascular necrosis nor the symptoms of pain Petitioner exhibited at the time complaint. Exhibit 1, pp. 18-19.

Dr. Domb published a letter dated October 5, 2015, which alleges that the AVN was caused or aggravated by Petitioner's work activities. No explanation is offered how the AVN, which is not in dispute, came to be present because of work. Dr. Domb asserts, contrary to all other evidence: "He had a noted incident of April 1, 2015..." PX3.

Reviewing the record, there is no testimony or documentary evidence of an injury occurring on April 1, 2015. Petitioner did not testify to an injury occurring on that date. Moreover, Dr. Domb's opinion regarding the causation issue of AVN is not accompanied by an articulated basis, scientific or otherwise.

Dr. Karlsson replied in a supplemental report of October 8, which was identified by him at his evidence deposition as Exhibit 3. In it, he opined that the AVN was natural progression which was not made worse by work activities. The progression arrived at the point where it needed to be addressed as it was, by hip replacement surgery. This point was not hastened by Petitioner's job. He opined that there is no relationship to or aggravation of AVN and work activities.

CONCLUSIONS OF LAW

Petitioner has the burden of proving by a preponderance of the evidence the injury complained of is causally to his employment, *Moore v. Industrial Commission*, 60 Ill. 2d 197, 203 (1975). It is the function of the Industrial Commission in a worker's compensation case to decide questions of fact and causation, to judge credibility of witnesses and to resolve medical evidence, *Foley Cadillac v. Industrial Commission,* 283 Ill. App. 3d 601, 607 (1996). In order to be compensable, an injury must "arise out of" an employee's employment; therefore, it must have its origin in some risk connected with or incident to the employment so that there is a causal connection between the employment and the injury. When an injury results from a danger to which the employee would have been equally exposed apart from the employment, that injury cannot be said to arise out of the employment. *Greene v. Industrial Comm'n.* (1981), 87 Ill.2d 1, 4, 56 Ill. Dec. 884, 885, 428 N.E.2d 476, 477.

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).

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).

In the instant matter, Petitioner testified that in March or April of 2015, his left hip area began to cause him pain. He went to his doctors, i.e. Dr. Akhal and Dr. David Domb. An MRI and x-

rays were performed and after conservative treatment, Petitioner underwent left hip replacement in August 2015. No specific incident or particular mechanism of injury is related in the records submitted by Petitioner. To Dr. Akhal at Adventist Health Partners, Liska does not allege an injury at work. The doctor notes that the onset of the pain with the problem worsening. Petitioner testified that his constant jumping off the delivery truck and carrying heavy loads caused his hip pain time over. The Arbitrator does not agree with this mechanism of injury and is persuaded by the opinions of Dr. Karlsson. According to Dr. Karlsson, Petitioner's work activities were not sufficient to cause his condition of ill-being regarding AVN. It is undisputed that Petitioner suffered from a condition of AVN, which, on this record, was not caused by his physical work activities. Importantly, while both sides agree that the petitioner suffered from the avascular necrosis, only Respondent supplied testimony as to its nature and medical cause.

Dr. Domb's letter of October 5, 2015 regarding the causal connection issue is not persuasive. No basis is stated for the doctor's opinion that a causal connection exists. The Commission is the finder of fact including on issues of causation. *Foley, supra.* Proof is to be by a preponderance of evidence. Dr. Domb's letter of October 5, s015, regarding causal connection, states an opinion without a basis. This does not carry the burden by a preponderance of evidence on the causal relationship between medical treatment and employment. It merely gives an opinion without a basis in the evidence and is not supported by the evidence before the Commission.[1] Nor is there evidence in the record that any incident aggravated a pre-existing condition of AVN.

Based upon the foregoing, the Arbitrator finds that the Petitioner's condition of ill-being, regarding his left hip, is not causally related to his work. Petitioner has a condition of avascular necrosis of the left hip which had been testified to as a longstanding and slow-developing bone condition of the hip joint. It is undisputed that the hip replacement treatment was needed to treat AVN however, no testimony was offered that AVN is either caused or aggravated by petitioner's work. Petitioner's claim for medical care and treatment, including the claim for union reimbursement, and for temporary total disability benefits and for permanent disability, is denied.

The Arbitrator finds and concludes that the Petitioner has not proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of his employment by Respondent therefore, no benefits are awarded, pursuant to the Act. As, an accident has not been proven, all other disputed issues are moot and will not be addressed.

---

[1] Parenthetically, it is noted that the letter of October 5, 2015 claims that the AVN was caused by a specific work accident on April 1, 2015, an assertion that is contradicted both by the Petitioner in his own testimony and the other proofs.

18IWCC0306

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
15 WC 21127
SIGNATURE PAGE

Signature of Arbitrator

June 14, 2017
Date of Decision

JUN 14 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Antonio Vega,

Petitioner,

vs. No. 16 WC 21266

Pace Cook DuPage Transportation,

18IWCC0307

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by the parties herein and proper notice given, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary disability and section 8(j) credit, and being advised of the facts and law, modifies and corrects 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).

Having carefully considered the evidence, the Commission ends the period of temporary total disability on December 30, 2016, the day Petitioner was videotaped exercising at the YMCA. The Commission viewed the surveillance video and found that the private investigator, Andres Colon, accurately summarized Petitioner's activities when he testified: "[The claimant] utilized exercise equipment. He kneeled and stretched on a padded mat. He kneeled and performed rolling push-ups with both hands on a wheeled instrument and stretched his back on a cylinder pad." The Commission notes that Dr. Goldvekht, one of Petitioner's treating physicians, kept Petitioner off work because of his ongoing complaints of severe pain in the neck and low back and self-reported disability. The surveillance video shows this not to be the case.

18IWCC0307

The Commission further notes that electrodiagnostic studies showed no abnormal findings relative to the cervical or lumbar spine. The Commission finds Petitioner was able to return to work as of December 30, 2016.

The Commission affirms the awards of medical expenses and prospective medical care, but corrects the award of medical expenses to related medical bills in evidence pursuant to sections 8(a) and 8.2, giving Respondent the stipulated section 8(j) credit of $23,400.43.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2017, is hereby modified and corrected 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 $416.16 per week for a period of 25 5/7 weeks, from July 4, 2016 through December 30, 2016, 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 related medical bills in evidence, pursuant to §§8(a) and 8.2 of the Act. Respondent shall be given a §8(j) credit of $23,400.43.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for a cervical epidural steroid injection, physical therapy and medications prescribed by Dr. Jain and Dr. Goldvekht, 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.

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: MAY 18 2018
o-03/22/2018
SM/sk
44

Stephen Mathis

Deborah Simpson

David L. Gore

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

VEGA, ANTONIO
Employee/Petitioner

Case# **16WC021266**

COOK DuPAGE TRANSPORTATION
Employer/Respondent

18IWCC0307

On 6/9/2017, 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 1.07% 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:

4188 LAW OFFICE OF KIRK MOYER
KRISTEN KOZLOWSKI
1146 WAUKEGAN RD SUITE 215
WAUKEGAN, IL 60085

0766 HENNESSY & ROACH PC
MIKE GEARY
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60602

18IWCC0307

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)

Antonio Vega
Employee/Petitioner

v.

Cook DuPage Transportation
Employer/Respondent

Case # **16** WC **21266**

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 **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **February 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 3, 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 conditions of ill-being of his head, cervical spine and lumbar spine *are* causally related to the accident.

In the year preceding the injury, Petitioner earned $**31,680.73**; the average weekly wage was $**609.24**.

On the date of accident, Petitioner was **57** 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 is entitled to a credit of $**4,001.40** 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 $**23,400.43** under Section 8(j) of the Act.

ORDER

Medical Bills

Respondent shall pay Petitioner $**21,686.25**, which is an amount equal to a total of the outstanding medical bills for the reasonable, necessary, and related medical services rendered Petitioner, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Respondent is entitled to a credit for medical bills previously paid through workers' compensation.

Respondent shall be given an 8(j) credit in the amount of $**23,200.43**.

Prospective Medical Care

Respondent shall authorize and pay for a cervical epidural steroid injection ("CESI"), physical therapy and medications as prescribed by Doctors Jain and Goldvekht, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits at a rate of $**416.16**/week for **34-1/7** weeks, from **July 4, 2016** through **February 27, 2017**, in accordance with Section 8(b) of the Act.

Respondent shall be given a credit in the amount of $**4,001.40** for TTD benefits previously paid to Petitioner,

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

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

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

Signature of Arbitrator

June 8, 2017
Date

ICArbDec19(b)

JUN 9 - 2017

18IWCC0307

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Antonio Vega

v. Case No. 16 WC 21266

Cook DuPage Transportation

FINDINGS OF FACT

It is undisputed that Petitioner sustained accidental injuries that arose out of and in the course of his employment with the Respondent on July 3, 2016. Petitioner was involved in a motor vehicle accident while working for Respondent as a para-transit driver. Petitioner was 57 years old at the time of the accident.

EMS states that Petitioner was a restrained driver in a vehicle (van or SUV) that was hit by a car (Ford Focus) and that Petitioner's vehicle then crashed into a brick wall. (Tr., PX 3, PX 1, pp. 49, 93) Petitioner estimated that he was driving his vehicle at approximately 30 m.p.h. at the time of impact. The car struck Petitioner on the driver's side. Petitioner's airbag deployed. Petitioner was taken by ambulance to Advocate Christ Medical Center where he was unconscious upon arrival. (PX 3)

Petitioner testified that after he was struck by the vehicle on July 3, 2016, the next thing he remembered was waking up in the hospital later that day.

The staff at Advocate Christ fully worked up Petitioner and discharged him to his home on July 4, 2016 at 1743. Upon discharge, the staff prescribed only Metformin,

which is a medication for diabetic patients. The discharge diagnosis was "Closed head injury; Driver injured in collision with motor vehicle in nontraffic accident." (PX 3)

On July 8, 2016, Petitioner sought treatment with Michael Foreman, M.D., who is associated with AMCI/Oak Park Medical Center. (PX 1) Petitioner testified that his prior attorney sent him to Dr. Foreman. At AMCI, he was diagnosed with a concussion with no loss of consciousness, cervical sprain, lumbar sprain, and lumbar radiculitis. On August 12, 2016, Petitioner underwent MRIs of the brain, cervical spine and lumbar spine. Dr. Foreman then referred Petitioner to Divya Agrawal, M.D. (PX 1)

On September 12, 2016, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Steven Mash, M.D. Petitioner described the motor vehicle accident and related the treatment rendered to him. He also told Dr. Mash that his medication includes Tramadol, Somnicin, Meloxicam, Omeprazole, and Gabapentin. Petitioner denied any prior difficulty of treatment about his neck and low back. Dr. Mash noted that Petitioner had vague subjective complaints at the root of his neck and some discomfort about the left side of his back. He conducted a physical examination of Petitioner. He also reviewed the medical records. (RX 8)

Dr. Mash reviewed a functional capacity evaluation conducted by a chiropractor, which did not include any recommendations. The chiropractor/evaluator found Petitioner capable of participating at the sedentary level when his job was qualified as heavy. Dr. Mash noted: "In truth, his job is described as medium in the description provided by the case manager, who was seen following the patient's visit today." (RX 8)

Dr. Mash also reviewed the MRI films and reports. He found the MRI of the brain to be unremarkable, the MRI of the cervical spine as showing disk bulging at C3-4, C5-6

and C6-7 with varying degrees of spinal canal and neural foraminal stenosis as well as some spondylosis, and the MRI of the lumbar spine as showing disc bulges at L4-5 and L5-S1 with varying degrees of spinal canal and neural stenosis with multilevel disc degeneration. According to Dr. Mash, "[t]he alleged work injury by virtue of reviewing the patient's underlying tests, which showed degenerative change in the neck and low back, appear to be a temporary flare-up of a pre-existing condition, which is not considered to be permanent in any way." He opined that "[c]ertainly, the mechanism of injury was significant enough to cause neck and low back difficulty for a period of time." Dr. Mash's impression was "sprain/strain, cervical and low back." Dr. Mash would not comment on Petitioner's head trauma because it is outside his area of expertise. Dr. Mash stated that the treatment to date was reasonable, necessary and related to the work injury, and found that Petitioner had achieved maximum medical improvement with the ability to return to work without restrictions. (RX 8)

Effective September 19, 2016, Dr. Agrawal released Petitioner to return to full-duty work. Dr. Agrawal wrote: "Although he does not feel able to return to his regular work duties due to an inability to push and pull heavy weight, and due to medication side effects, he reported to be at MMI and with return to regular duty work as per his IME." (PX 1, pp. 38, 39)

Petitioner testified that he attempted to return to work on September 19, 2016, at which time his head and back hurt and he could not work anymore. Petitioner testified that he returned to work on September 20, 2016, but found his work duties to be more difficult.

On September 23, 2016, Petitioner sought treatment with Aleksandr Goldvekht, M.D., at Advanced Physical Medicine (PX 5, PX 2), who performed an EMG that revealed carpal tunnel syndrome and no evidence of cervical or lumbar radiculopathy. Notwithstanding the EMG results, Dr. Goldvekht took Petitioner off work and diagnosed bilateral upper extremity radiculitis and bilateral lower extremity radiculitis. Dr. Goldvekht ordered physical therapy for Petitioner and later referred him to Neeraj Jain, M.D., for an injection. (PX 5)

Petitioner testified on direct examination that before Respondent hired him in November 2009, he drove a trailer and he also drove a dump truck. With respect to the physical demands of his position with the Respondent, Petitioner testified that his job entails driving a van, pushing disabled persons in wheelchairs up a ramp, securing the wheelchairs, and pulling disabled persons in wheelchairs out and lowering them down a ramp. The medical records indicate that Petitioner told his treaters such job required him to push/pull up to 400 lbs.

Petitioner testified on direct-examination that he underwent the Section 12 examination with Dr. Mash without the benefit of an interpreter, and further testified that his wife was not allowed in the examination room to help interpret.

On cross-examination, Petitioner testified that he answered all of Dr. Mash's questions truthfully, and that he told Dr. Mash that he had neck and low back pain. Petitioner further testified that he has not used an interpreter during the 7 years he has worked for Respondent. He has asked for a translator for written materials. Petitioner acknowledged that before he began working for Respondent, he completed a 5-day, 8

hr./day, training program. Petitioner testified that the entire 40-hour training program was conducted in English.

During direct examination, with the aid of an interpreter, Petitioner gave the following answers in English: "A white woman, about 40 to 45 ..." and "The lady from the office ..."

With regard to his current condition, Petitioner testified that not 1 day passes without pain.

Petitioner also testified that the severe pain in his neck and low back that he felt when he saw Dr. Goldvekht on September 23, 2016 prevented him from working at that time, and he further testified that this was the same pain he experienced at the time of Arbitration. He testified that the same pain he was feeling on September 23, 2016 prevents him from working today.

Petitioner testified that on October 27, 2016, he reported to Dr. Jain that he has pain in the upper back, low back, neck, head, left arm, left hand, bilateral feet and right leg, and he told Dr. Jain that the pain was worse with walking, standing, sitting, bending forward, extending backwards, sudden movements, and extending to the left and to the side. Petitioner testified that he told Dr. Jain that he is able to perform activities of daily living, but with a lot of discomfort. Petitioner testified that he reported severe pain when he saw Dr. Jain on December 6, 2016, at which time Dr. Jain administered an epidural steroid injection. On December 14, 2016, Petitioner reported that he felt much better since having the injections. (PX 5, p. 477)

Petitioner testified that the pain he described to Dr. Jain on December 6, 2016 was the same pain he described on September 23, 2016. Petitioner testified that he

can bend over at the waist a little and squat a little, but stated that his inability to push a wheelchair as well as his inability to sit for too long (while driving) prevents him from working in his pre-accident position for Respondent.

Petitioner denied any other employment outside of Respondent, and testified that Respondent has provided him with his only source of income. Petitioner testified that during the pendency of this claim, he has not operated Ruby Engraving. (RX 6) On cross-examination, Petitioner testified that he owns 2 buildings, 1 of which contains 2 apartments where his daughters live and the other contains a rent-paying tenant. Petitioner testified that he receives $1,000.00 per month in rent from his tenant.

Petitioner also testified that he has group health insurance and has not tried to submit the disputed medical treatment through his group health insurance.

Petitioner testified that he would like to return to work for Respondent, but would first like to undergo the interventional pain management as recommended by Doctors Goldvekht and Jain.

Maria Concepcion Vega testified on behalf of her husband. She testified as to Petitioner's ability to speak English. She stated that at times Petitioner needs her help to pronounce an English word and to express something in English. She also testified with regard to his current complaints of pain, as well as about the interaction of Respondent's nurse case manager with Dr. Foreman's staff when she and her husband were present.

Andres Colon of the Robison Group testified on behalf of Respondent. He is a field investigator who conducted surveillance of Petitioner. He testified about what he witnessed on September 16, 2016 and December 30, 2016. During these 2 days of

surveillance, approximately 22 minutes of video was obtained that depicts Petitioner walking a dog, getting into and out of his van, driving the van, and exercising at the YMCA. Petitioner was seen performing a pull-up or using the Gravitron, performing rolling push-ups with both hands on a wheeled exercise instrument, doing sit-ups, kneeling /stretching, and utilizing exercise equipment.

Petitioner testified that, currently, that he can drive 30-40 minutes but after that he gets a little tired. He testified that he has problems with his sleep and that he has headaches. He testified that not 1 day goes by that he has no problem with his head, neck or low back. Some days when he wakes up he is fine, and other days he "can't get up" – he has to walk 5 or 6 steps before he can straighten up and walk normally. After bending a little bit to wash dishes, he notices that he is hurting. He finds that his back and his side hurt the most. Petitioner further testified that he can do the activities of daily living, but with a lot of discomfort. He testified that he can swim a little, bend at the waist a little, and squat a little - but must squat slowly. He can walk, but not like he could before the accident. He testified that he used to like to run, but cannot do it any longer.

CONCLUSIONS OF LAW

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

After reviewing the totality of the evidence, the Arbitrator finds, by a mere preponderance of the weight of the evidence, that Petitioner's current conditions of ill-being of his cervical spine, lumbar spine and head (closed head injury) are causally related to the accident.

The Arbitrator finds the opinions of Doctors Foreman, Jain and Goldvekht to be more persuasive than those of Dr. Mash.

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*, 77 Ill. 2d 1 (1979) citing *Holiday Inns of America v. Indus. Comm'n*, 43 Ill. 2d 88, 89-90 (1969) and *Proctor Community Hospital v. Indus. Comm'n*, 41 Ill. 2d 537, 541 (1969).

Dr. Mash, on September 12, 2016, took a history from Petitioner and conducted a thorough physical examination of him. Petitioner testified that he answered all of Dr. Mash's questions truthfully. Dr. Mash also reviewed the following: the medical records of Advocate Christ Medical Center, the MRI films and reports of the brain, cervical spine and lumbar spine from Molecular/Advantage MRI, the medical records of AMCI-Oak Park Medical Center/Dr. Foreman/Dr. Agrawal and a Functional Capacity Evaluation. (RX 8) Dr. Mash wrote that the chiropractor/evaluator found Petitioner capable of participating at the sedentary level. Neither side offered the Functional Capacity

Evaluation into evidence. Dr. Mash opined, based on the history as provided by Petitioner (his subjective complaints are noted), that there are no objective findings on physical exam or diagnostic study. Dr. Mash wrote that Petitioner's underlying tests showed degenerative change in the neck and low back, and that the work injury appears to be a temporary flare-up of a pre-existing condition, which is not considered to be permanent in any way. His impression was sprain/strain of cervical and low back. He would not comment on Petitioner's head injury.

The Arbitrator notes the following:

1. In an apparent attempt to poke holes in Dr. Mash's examination findings, Petitioner testified that Dr. Mash did not provide him with a Spanish-English interpreter. Yet, there is no evidence that Dr. Foreman or any staff member at AMCI/Oak Park Medical Center provided Petitioner with an interpreter. There is no evidence that Dr. Goldvekht or any staff member at Advanced Physical Medicine provided Petitioner with an interpreter. There is no evidence that Petitioner required the use of an interpreter while treating with these providers. Therefore, the Arbitrator finds that Petitioner demonstrated over the course of his treatment, during the Section 12 examination, and at Arbitration, that he did not require the services of an interpreter to orally communicate in English. Petitioner conceded that he completed a 5-day training program for Respondent that was conducted in English.
2. Following a normal neurological examination and a repeat CT scan of the brain in which no significant intracranial abnormality was seen, the staff at Advocate

Christ Hospital discharged Petitioner on July 4, 2016. (PX 3) After such discharge, Petitioner's first documented complaints of memory problems took place 1 month later - on August 3, 2016 - despite the fact that he voiced various other complaints to the staff at AMCI on 7/8, 7/11, 7/12, 7/14, 7/18, 7/19, 7/21, 7/25, 7/26, 7/28, 8/1 and 8/2. (PX 1)

3. The list of body parts about which Petitioner complained expanded over time. More than 10 weeks after the accident, Petitioner first complained of ringing problems in his ears and hearing difficulties. (RX 8) Petitioner testified that on October 27, 2016, he reported to Dr. Jain that he has pain in the upper back, low back, neck, head, left arm, left hand, bilateral feet and right leg.
4. Petitioner's testimony and his complaints to the treating physicians are somewhat inconsistent with his behavior in the surveillance video of September 16, 2016 and December 30, 2016. The video does not show Petitioner pushing or pulling a heavy object, but does show him doing a pull-up or using the Gravitron in which he lifts all or part of his body weight, respectively, performing push-ups with his hands on a wheeled instrument, doing sit-ups, and exercising on a machine. On rebuttal, Petitioner testified that his doctors told him that all the exercise he can do is good for him. Also in the video, Petitioner is shown walking his dog, getting in and out of his van, and driving the van. After carefully reviewing the surveillance video admitted into evidence, the Arbitrator finds, from a layman's point of view, that Petitioner did not exhibit any pain behaviors such as walking with an antalgic gait, grimacing, stretching, bending or rubbing. Yet, the Arbitrator notes that Petitioner did not move quickly in the video; Petitioner

testified that he used to like to run, but can no longer do so, and that he can walk, but not like he could before the accident.

Dr. Jain, in a Patient Status Form dated February 8, 2017, provided the following diagnosis: "Lumbar facet syndrome, Lumbar discogenic pain, Lumbosacral radiculopathy, Cervical facet syndrome, Cervical discogenic." (PX 2) Dr. Jain checked the box that indicated this is a work-related injury. He has kept Petitioner off work and prescribed medications, physical therapy and "CESI", or cervical epidural steroid injection. (PX 2) On February 13, 2017, Dr. Goldvekht assessed Petitioner with a cervical disc with bilateral upper extremity radiculitis, a lumbar disc with bilateral lower extremity radiculitis, and a right knee injury. He opined that Petitioner's condition is guarded. Dr. Goldvekht kept Petitioner off work, prescribed medications and physical therapy, and advised him to follow up after the interventional pain management. (PX 2)

The Arbitrator finds it significant that there is no evidence that prior to July 3, 2016, Petitioner had complaints of, or treatment for, his head, cervical spine or lumbar spine.

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. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

The Arbitrator notes that Dr. Mash reviewed the diagnostic tests, which showed degenerative change in the neck and low back. Dr. Mash then wrote that the work injury appears to be a temporary flare-up of a pre-existing condition. However, when he

offered his impression, he indicated that Petitioner sustained a "[s]prain/strain, cervical and low back." The Arbitrator asks: "Which is it then - - a temporary flare-up of a pre-existing condition or a sprain/strain of the cervical and low back?"

Moreover, Dr. Mash opined that "[c]ertainly, the mechanism of injury was significant enough to cause neck and low back difficulty for a period of time." At Advocate Christ Hospital, Petitioner underwent CT scans of the cervical, thoracic and lumbar portions of the spine. (PX 3) From July 8, 2016, when he first received treatment from Dr. Foreman and AMCI, to the date of Arbitration, Petitioner has had complaints of neck and low back pain and medical care for his cervical spine and lumbar spine. (PX 1, PX 5, PX 6) It is true that the EMG revealed carpal tunnel syndrome and no evidence of cervical or lumbar radiculopathy. Yet, the MRIs revealed 3 disc bulges in his cervical spine and 2 disc bulges in the lumbar spine.

Petitioner testified, and the records reflect, that Petitioner received temporary pain relief from the 2 injections to his low back and 1 injection to his neck.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary, but that Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

Petitioner identified the unpaid medical bills.

Based on the foregoing, the Arbitrator finds that Respondent shall pay Petitioner $21,686.25, which is an amount equal to a total of the outstanding medical bills (PX 1, PX 5, PX 6), pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The parties agree that Respondent claims they paid $23,400.43 in medical bills through their group plan for which credit may be allowed under Section 8(j) of the Act. (AX 1)

K. What temporary benefits are in dispute? TTD

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to TTD benefits at a rate of $416.16/week from July 4, 2016 through February 27, 2017. Respondent is entitled to a credit in the amount of $4,001.40 for TTD benefits previously paid.

Dr. Mash is the only physician to release Petitioner to return to full-duty work, but the Arbitrator has found the opinions of Doctors Foreman, Jain and Goldvekht to be more persuasive than those of Dr. Mash.

Petitioner returned to work on September 19 and 20, 2016, but could not work anymore because his head and back hurt him. Petitioner's job entails driving a van, pushing disabled persons in wheelchairs up a ramp, securing the wheelchairs, and pulling disabled persons in wheelchairs out and lowering them down a ramp.

Petitioner denied any other employment outside of Respondent, and testified that Respondent has provided him with his only source of income. Petitioner testified that during the pendency of this claim, he has not operated Ruby Engraving. (RX 6) On cross-examination, Petitioner testified that he owns 2 buildings, 1 of which contains 2

apartments where his daughters live and the other contains a rent-paying tenant. Petitioner testified that he receives $1,000.00 per month in rent from his tenant.

The Arbitrator recognizes that the $1000.00/month in rent that Petitioner has received does not constitute "working" and would not be considered wages. Please see *Sunny Hill of Will County v. Illinois Workers' Comp. Comm'n*, 14 N.E.3d 16, 383 Ill. Dec. 184 (3d Dist. 2014)

K. Is Petitioner entitled to any prospective medical care?

Based on the Arbitrator's finding on the issue of causation, on the opinions of Doctors Jain and Goldvekht, and on Petitioner's testimony, the Arbitrator finds that Petitioner is entitled to prospective medical care in the form of a CESI, physical therapy and medication, as prescribed by these physicians, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Brian T. Cronin
Arbitrator

6-8-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIBEL SIMENTAL,

Petitioner,

18IWCC0308

vs.

NO: 14 WC 31101

UNISTAFF,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability benefits, and medical expenses both current and prospective, 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 Arbitrator found that Petitioner proved she sustained a work-related accident on August 12, 2014 which caused conditions of ill-being of her left wrist, elbow, and shoulder. The Arbitrator awarded Petitioner 122&5/7 weeks of temporary total disability benefits, $896.79 in under payment of temporary total disability benefits, $46,431.46 in submitted medical expenses, and ordered Respondent to authorize and pay for prospective shoulder surgery recommended by Dr. Silver. The Commission affirms the Decision of the Arbitrator concerning accident and causal connection to Petitioner's wrist and elbow conditions. However, the Commission finds that Petitioner did not sustain her burden of proving her shoulder condition of ill-being is causally related to the accident and modifies the Decision of the Arbitrator accordingly.

Furthermore, the Commission notes that although this matter was not arbitrated pursuant to section 19(b), the Arbitrator awarded prospective medical treatment and did not enter any award for permanent partial disability. Therefore, the Commission remands the matter to the Arbitrator to consider a proper permanency award, consistent with this decision.

18IWCC0308

Findings of Fact & Conclusions of Law

1. Petitioner testified through a Spanish interpreter that she was currently unemployed but worked for Respondent in 2014. It is a temporary staffing agency which sent her to Peerless, a company which assembles pieces for TV mounts. She started there "more or less" in August 2013. Most of the time she worked as an assembler, but sometimes she worked in packaging. As an assembler she would put pieces together by turning them like a screwdriver. Then one worker would lift the completed wall mount so that another worker can put it in a bag. She demonstrated and her arms were at above shoulder level. The wall mounts weigh about 50 pounds "more or less."

2. On August 12, 2014, she had just assembled a large wall mount. She lifted the fully-assembled wall mount up to get it into a bag. She felt tightening in her left wrist and pain all the way to her elbow. She also felt a little bit of pain in her left shoulder. As she demonstrated, the Arbitrator noted that she had her elbow outstretched at shoulder level with her forearm above shoulder level. She had to lift it high because the table was almost waist high. She had to lift the mount almost to the level of her head. She reported the accident to her supervisor and completed her shift. She also returned to work for two days.

3. Respondent sent Petitioner to Cadence Clinic on August 14th. Her primary complaint was regarding her left wrist and elbow. She also mentioned her shoulder. She had an MRI on her left wrist in September 2014 and an MRI of her left shoulder in November. Thereafter, she began treating with Dr. Silver for her shoulder. He prescribed a shoulder injection and medication. She continued to treat with Dr. Silver and last saw him on November 30, 2016. He recommended surgery for a torn tendon. She wanted the surgery recommended by Dr. Silver.

4. On cross examination, Petitioner testified she started to treat with Dr. Silver on November 21, 2014. He only treats her shoulder and not her wrist or elbow. Currently, she had no pain in her elbow or wrist. She remembered telling Dr. Murphy, Respondent's Section 12 medical examiner, that the accident involved using a torque gun, and that while she was using that tool with her right hand and attempted to lift the part with her left, she felt a pop in her wrist. She then clarified that "not with the gun though" but when she lifted the part. She only used an overhead pneumatic gun once. There were also pencil torque guns, which are drills shaped like pencils.

5. Petitioner denied that she met with Shawn Hamilton on the day of the accident. He came to see her two days later, on August 14. He did not come to talk to her about the accident. They did not discuss the accident/injury. Mr. Hamilton did not complete the accident report; "it was the other guy, maybe the manager." Petitioner agreed she signed an accident report on August 14. No employee from quality control assisted her in filling out the report. Nobody did; she wrote everything in Spanish. She was shown RX3, identified as a "minor injury report." Petitioner agreed that she signed it.

18IWCC0308

6. Petitioner agreed that when she went to Cadence on August 14, there was an interpreter and she told the doctor all her complaints. The doctor examined her left wrist and elbow but not her shoulder. The doctor prescribed physical therapy. She complained of left wrist and elbow pain at that time. She agreed that her left shoulder was not examined until September 15, 2014, but Petitioner insisted she told "the doctor, the insurance doctor" that her shoulder was hurting. He indicated that it was nothing to worry about because it emanated from her wrist/elbow.

7. Petitioner also agreed that she sought treatment at the Spinal Rehab & Wellness Center on September 18, 2014. She was shown a pain diagram she prepared on that date, which indicated pain in the left elbow and wrist. The doctor there examined her left wrist and elbow, and tests were ordered for her wrist. When she returned on October 1, 2014, she complained of left-shoulder pain, which she woke up with. Her elbow and wrist were improving with treatment. Respondent's Section 12 medical examiner examined her elbow and wrist but not her shoulder. He did ask her to lift her arm.

8. On redirect examination, Petitioner again testified that she currently had no pain in her elbow or wrist. On the day of the accident, she was working as an assembler, and she was responsible for actually lifting the 50-pound assembled mount by herself with two hands and move it to the side. She was not working in sub-assembly at the time. The parts in sub-assembly are much smaller. She was injured when she lifted the assembled mount and not while assembling it. She did not initially seek treatment of her shoulder because the most severe pain was in her wrist and elbow. The pain in her shoulder progressed gradually. As her elbow/wrist pain decreased, she began seeking treatment for her shoulder. Currently, she had pain in her shoulder.

9. Sean Hamilton was called to testify by Respondent; he was not being paid for his testimony. He was hired by Peerless in March 2014 as pack line supervisor and was employed in that position on the date of the accident. His job involved continuously walking the production floor ensuring that everything was being done properly. He worked the same shift as Petitioner. He could see the entire floor and every assembly station from his desk and watched Petitioner while she was working.

10. Mr. Hamilton also acted as "first responder" in which he responded to any accident or injury. Employees, both full-time and part-time, are notified at orientation that they are required to inform supervisors immediately of any accident. "They all know how to fill out the accident reports." The policies and reports of the monthly safety meetings are provided in both English and Spanish. Mr. Hamilton was also on the safety committee which would meet within 24 hours of an injury to determine what happened and to discuss possible remedial action.

11. Mr. Hamilton also testified that RX10 depicts the tasks of packers. The product does not leave the table. One packer slides the product into the bag, and passes it to the second packer who picks up the product and places in the box. "Nobody ever lifts the box other than the guy at the end of the line, not the assemblers." Mr. Hamilton reiterated that the basic process is used to assemble and pack all mounts, regardless of size.

18IWCC0308

12. Mr. Hamilton explained that in the sub-assembly process, employees use hand tools and pneumatic tools. "Mostly pneumatic tools are the primary source of how we assemble because you have to reach the torque value that is set forth by the engineers." Some of these tools are overhead hanging from a tension wire, or actually on the table connected to air lines. They are pretty much the same in the assembly areas.

13. As of August 2014," Mr. Hamilton was "very much" familiar with the group Petitioner was assigned to. He agreed with Petitioner that her group included Angel, Javier, and Nicolas. Javier and Petitioner assembled, Nicolas filled, and Angel packed. Mr. Hamilton assigns the various tasks and makes sure that women would assemble and would not pack or lift. Petitioner would never act as a packer.

14. Mr. Hamilton testified he became aware of Petitioner's alleged accident on August 14th, when Nicolas told him she injured her wrist. He immediately went to Petitioner, who was in assembly, and informed her that she had to fill out an accident report. He brought her to his desk and had Maria from quality control to translate. At that time, the pack line manager "walked up as well." Petitioner filled out the report, identified as RX3, with the assistance of Maria. Mr. Hamilton then contacted Respondent's on-site representative for her to talk to Petitioner and about her going to the clinic, because she said she wanted to see a doctor.

15. Mr. Hamilton also explained that Peerless keeps records of all the workers who work on particular products and when. On August 12, 2014, the only assembly being done was sub-assemblies. He no longer works at Peerless, but he pulled the records for that day. The only products they were assembling on that day were subject to the process outlined in RX2. Thereafter, packaging would be done subject to the process outlined in RX10.

16. Mr. Hamilton knew that Petitioner had not performed the assembly tasks she testified to because there was "no documentation that they were ever worked on that product," there was no shop order for the product, and he walks the floor noting what employees are doing. He identified RX11, which is a report he prepared on August 18, 2014, though it was signed by the shift manager. He prepared the document based on the information Petitioner provided. She informed him that she hurt her wrist in the assembly process. She did not have any other complaints. In her report, she also noted pain in her elbow, but she did not mention that to him. She did not report lifting parts weighing 50 pounds, "and the parts in that particular operation do not weigh that." Peerless keeps records of what each assembler and each team does with start time and stop time. There would not have been any lifting of mounts at her station.

17. On cross examination, Mr. Hamilton agreed that Petitioner reported an injury to Nicolas, but he noted that she did not follow proper protocol because he was not a supervisor, but a team leader. In her job as assembler, the heaviest part Petitioner would have to lift would weigh one to 15 pounds. Petitioner did work in final assembly but "never" worked as a packer of that product. In working final assembly, Petitioner would never have to lift anything up to 50 pounds.

18IWCC0308

18. Mr. Hamilton was shown a job description for assembler which he prepared. He agreed that it mentioned duties including lifting up to 50 pounds. Assemblers do not have to lift the product to get it to packing. They are "actually on a fixture. It has four clamps that hold it in place. You would detach those clamps and set it over to the side." When asked if the assembler is lifting, Mr. Hamilton responded, "you could say you are lifting it but you are not lifting it any higher that what the fixture is currently and which is waist high."

19. Mr. Hamilton also testified that in her accident report Petitioner indicated she worked on assembly with a pistol-grip gun and injured her wrist. He also agreed that she indicated "she was lifting and injured herself." He also agreed that he had her listed as a packer. He noted that "it's a loose term in pack line." In the job descriptions they had assemblers and packers and Peerless wanted "to convert all of that into just packer in general or packing assembly."

20. Mr. Hamilton noted that while her report indicated she was injured lifting, that was not what she reported to him. He did not review her report, it was in Spanish and he does not speak Spanish. He agreed that he signed off on something he did not understand. He knew that Petitioner's group was working sub-assembly the morning of the accident.

21. On redirect examination, Mr. Hamilton testified Petitioner was assembling units as depicted in RX2. He knew Petitioner would only lift less than 25 pounds in final assembly, because he weighed the mount as well as the entire packaging including everything, and it weighed 31 pounds.

22. The Accident report was dated August 14, 2014. It is in Spanish with an English translation. Petitioner reported that on August 12 she developed "pain in the wrist up to [her] elbow." According to the English translation, Petitioner "was carrying a pizza (*sic*) and when [she] attempted to pick it up [her] hand gave way and [she] felt a pull in [her] wrist and felt numbness of fingers in [her] hand and a pain that went up to [her] elbow."

23. The investigation report was dated August 18, 2014 and indicated that Petitioner's accident was on August 12th and was reported on August 14. She reported left arm/wrist pain after using a torque gun

24. The medical records show that on August 14, 2014, Petitioner presented to Dr. McCarthy at Cadence Occupational Health with acute 6/10 posterior left wrist pain when moving parts of assembly on August 12. She stated she was lifting 40 pounds repetitively at work and noticed the pain in the hand/wrist and up to the elbow. Dr. Dr. McCarthy diagnosed wrist sprain, provided a wrist brace, prescribed Ibuprofen and occupational therapy, and imposed a two-pound left-hand work restriction.

25. Petitioner presented to Dr. Baksinski a week later for follow up with 6/10 wrist pain which intermittently radiated to the elbow, and if more intense to the shoulder. The pain could rise to 8/10 with activity. Dr. Baksinski's diagnosis included lateral epicondylitis.

18IWCC0308

26. On August 27, 2014, Petitioner was initially evaluated by occupational therapy for left wrist sprain and lateral epicondylitis, on referral from Dr. Baksinski. She was working on the assembly line using an air pressure machine. "When she picked up the machine she felt a pull on her wrist and pain went from her wrist up to her elbow." Her pain was currently 6/10 but could rise to 10/10. She had reduced strength and range of motion and was unable to perform her normal job.

27. On September 18, 2014, Petitioner presented to Dr. Dhutia, D.C., apparently for therapy. She reported she was injured on August 12, while lifting a TV base weighing about 50 pounds to put in a box. She felt a crack in her wrist and sharp pain. It got more painful and she went for six physical therapy sessions and e-stimulation, with little benefit, so she decided to go there. They would start with an MRI of the wrist.

28. On October 1, 2014, Petitioner returned and reported her elbow pain was worse (8/10), her wrist pain was better (3/10), and she started having shoulder pain (6/10). She did "not recall picking up anything [heavy] or falling down. She states just woke up with it." The therapist informed Petitioner her initial injury could lead to shoulder problems over time because of favoring the wrist/elbow, or delayed onset of pain. Petitioner reported she had no shoulder problems prior to the accident.

29. Petitioner returned to Dr. Dhutia on November 12, 2014 after about 16 therapy sessions, in which she reported consistently improving elbow and wrist conditions and consistent 8/10 shoulder pain. Petitioner reported she had no elbow pain and wrist pain was 80% better at 2/10. Dr. Dhutia noted that "the shoulder pain started after the wrist pain, but its (*sic*) due to work and lifting the TV part with her left arm-initially most of the pain was in the wrist but now have a lot of pain in the shoulder." He ordered an MRI of her shoulder.

30. The MRI of the left wrist showed minor negative ulnar variance, a small cyst of the lunate with adjacent reactive marrow edema, and a cyst of the scaphoid bone. The MRI of the left shoulder showed findings compatible with mild bursitis of the subacromial/subdeltoid bursa with possible associated tendinosis with no evidence of rotator cuff tear. Also noted was hyperintensity in the coracoclavicular interval, which was of questionable significance as the ligaments appeared intact and an isolated sprain of the of the coracoclavicular ligaments would be unusual.

31. Dr. Murphy, a board-certified orthopedic surgeon, testified by deposition on June 4, 2015. Respondent requested that he examine Petitioner and present opinions regarding diagnosis, medical necessity, maximum medical improvement, and causation. On October 24, 2014, he generated a report after his examination and review of her medical records. There was an interpreter available at the time of his examination.

32. Petitioner reported she was working with a torque gun and when she was trying to lift a part with her left hand, she began to have pain in her wrist that radiated into the forearm. "She stated that the shoulder pain came on later, that she did not have pain initially in her shoulder."

18IWCC0308

33. Petitioner initially sought treatment at Cadence. An MRI was taken and she was prescribed anti-inflammatories and had a course of physical therapy. Dr. Murphy did not have any records from treatment after Cadence. In his review of the Cadence records from August 14, 2014 through September 9, 2014, there was no recorded complaints regarding Petitioner's shoulder or of any treatment to her shoulder. In addition, the physical therapy records did not report a history of Petitioner lifting a heavy wall mount causing left shoulder pain. During his examination, Petitioner complained of a burning/throbbing ache in her shoulder and had difficulty with any above-shoulder activities, sharp/stabbing pain in the elbow, and some mild pain in the wrist.

34. On examination, Dr. Murphy found significantly reduced range of motion in the left shoulder, both passive and active, with some positive impingement signs. There was tenderness in the elbow, mild tenderness on the ulnar side of the wrist, but there no evidence of instability of the wrist. There was also no evidence of carpal tunnel syndrome or abnormal nerve function. After his examination, Dr. Murphy diagnosed left wrist strain, left elbow epicondylitis, and left shoulder impingement syndrome.

35. Dr. Murphy opined that the wrist strain was caused by the reported accident, because the rotational injury would be consistent with a strain of the TFCC. However, he also opined that the cysts and elbow condition were not caused by the accident. Petitioner's report of the torsional injury would not involve strain of the pronators or with wrist flexors what would be involved with medial epicondylitis. He also felt Petitioner's shoulder condition was not caused by the accident. He based that conclusion on the fact that Petitioner only reported shoulder symptoms after the initial injury and the torsional injury would not have affected her shoulder. He thought she should be at maximum medical improvement for her wrist within six to eight weeks.

36. On cross examination, Dr. Murphy agreed that his opinion that Petitioner's shoulder condition was not caused by the reported accident was based on medical records and his review of the description of Petitioner's job. He agreed that on August 21, 2014, Petitioner did mention pain radiating to her shoulder; he conceded that she did have some shoulder complaints at that time. He also noted that while a physical therapy record from August 27, 2014 indicating some reduced shoulder abduction in certain positions, that was basically "a nerve glide test. That's not really an exam finding for the shoulder." Dr. Murphy agreed that the records he was provided began on September 4, 2014, but he was shown previous records prior to the deposition.

37. Petitioner's history of the mechanism of her accident was that she was attempting to lift a part "with her left hand and using a torque gun with her right hand, and as she turned the wrist over she felt a pop in her wrist." Dr. Murphy agreed that a lifting 40 to 50 pounds can cause a strain of the rotator cuff, depending on the position of her arm. The notation of shoulder complaints Dr. Murphy was shown, did not change his causation opinion.

38. Dr. Murphy noted that her reference to shoulder pain was that it radiated from the wrist. "Typically, patients with impingement syndrome and rotator cuff issues will have pain that starts in the shoulder and radiating down the arm, and will complain of pain with any

18IWCC0308

attempts at movement of the shoulder itself. He also noted that she reported to him that her shoulder pain began later. He agreed that if Petitioner had exhausted conservative treatment, arthroscopic shoulder surgery would be warranted.

39. On redirect examination, Dr. Murphy testified that any impairment regarding working at her previous job basically stemmed from her shoulder and elbow conditions and not her wrist condition. "The shoulder would likely be the lion's share of the complaint at this stage." He reiterated that the August 21, 2014 treatment note suggests that Petitioner's pain was radiating in the direction of the shoulder and did not originate in the shoulder. He also noted that there did not appear to be any examination of the shoulder at that time. The only examination and treatment was regarding the wrist and elbow. There was not even any diagnosis related to the shoulder at that time.

40. Dr. Silver, also a board-certified orthopedic surgeon, testified by deposition on October 9, 2015. He first saw Petitioner on November 21, 2014. She reported that she was lifting a heavy TV wall mount on August 12, 2014 and felt pain in her left shoulder as well as her wrist and elbow. He was only concerned with her shoulder, which she reported was normal prior to the accident.

41. After his examination and review of her MRI, Dr. Silver diagnosed left rotator cuff impingement. He opined that the impingement was the result of her work injury. He administered a cortisone injection. Petitioner reported temporary relief from the injection but her symptoms returned. The temporary relief Petitioner reported from the injection confirmed the diagnosis of impingement. Dr. Silver concluded Petitioner had exhausted conservative treatment and recommended arthroscopic surgery.

42. Dr. Silver continued to treat Petitioner for management of her pain while awaiting authorization for surgery. He kept her off work. He noted that Dr. Murphy had recommended conservative treatment that Petitioner already had. Dr. Silver also disagreed with Dr. Murphy's conclusion that Petitioner's shoulder condition was not related to the accident, because "basically the mechanism of injury she described to [him] was an appropriate cause to cause damage and inflammation to the rotator cuff" and there was no previous history of a prior shoulder condition. "So, with all due respect, of course it was caused by this accident, there's nothing else present."

43. Dr. Silver noted that it is "hard to describe where pain is" and it can change over time. A person may not have initial pain because there is no bleeding. "The pain is mediated by progressive inflammation." Then as the inflammation increases and the swelling increases over time," it starts to rub on the bone and the rotator cuff gets swollen causing more rubbing. It is a vicious cycle. Different patients report pain in different areas of the shoulder.

44. On cross examination, Dr. Silver testified he did not know whether Dr. Dhutia referred Petitioner to him. He was not provided any records from Dr. Dhutia. He had no records of previous treatment except the MRI.

18IWCC0308

45. Dr. Silver actually reviewed the MRI film and agreed with the interpretation of the radiologist, that there was no evidence of a rotator cuff tear and there were no tears in the tendons. "Theoretically," the bursitis could develop absent trauma. The finding of bursitis was not consistent with her age (36). It is not a condition normally associated with activities of daily living. Negative x-rays simply ruled out conditions such as arthritis, bone spurs, or calcium deposits.

46. Dr. Silver also testified that he arrived at his opinion of causation "partially" on the history Petitioner reported. She told him she was assembling TVs and lifting a heavy wall mount on August 12, 2014 and felt pain in her left shoulder, elbow, and wrist. She did not provide him any accident reports. If the facts that made up her history changed, that could "possible" change his opinion on causation. She had some initial pain in her shoulder, but it became more pronounced over time. He did not recall the specifics of her lifting, but he believed she was lifting it alone.

47. Dr. Silver agreed that the pain diagram Petitioner executed in Dr. Dhutia's office on September 18, 2013 did not indicate pain in the left shoulder and Dr. Dhutia did not note any pain in the shoulder. Dr. Silver agreed that his work status notes related to her shoulder condition and not her wrist or elbow. He also agreed that she did not mention shoulder pain in several visits with Dr. Dhutia.

48. On redirect, Dr. Silver testified that being shown five instances in which Petitioner did not have left-shoulder complaints to Dr. Dhutia did not change his causation opinion. She related to him that her elbow and wrist were the focal points of her pain and problems and the shoulder was much more minor and she hoped it would go away. However, the shoulder pain then slowly increased. It did not matter if Petitioner was lifting below shoulder level, at chest level, or above shoulder level. Lifting a 50-pound item was sufficient to cause damage to the rotator cuff. Generally, regarding rotator cuff impingement "some people will get immediate onset, but most people don't. It might start as minor but get worse and worse."

In looking at the entire record, the Commission concludes that Petitioner did not sustain her burden of proving that the condition of ill-being of her left shoulder was caused by her work-accident on August 12, 2014. We base that conclusion on her delay in reporting shoulder pain, as well as inconsistencies in her reported mechanism of injury between her testimony compared to her accident report, her history during her initial medical treatment, and her statement to Respondent's Section 12 medical examiner.

While Petitioner testified that she injured her left upper extremity lifting a TV mount, her accident report and initial history to medical providers indicated only injury to her wrist and elbow through using a tool while assembling parts. The first time she related the history of lifting a 50-pound TV base as the cause of her injuries was on September 18, 2014, more than a month after the accident. Even then she did not report shoulder complaints, but related the incident only to her wrist and elbow pain. The first time she ever reported significant shoulder complaints was to her chiropractor on October 1, 2014. At that time, she reported that she woke up with shoulder pain and did not remember lifting anything heavy or falling down.

18IWCC0308

Finally, the Commission finds the testimony of Mr. Hamilton persuasive. He was a neutral party with no apparent motivation to provide untruthful testimony. His explanation that he assigned team members to specific tasks and he never assigned women to the more physically demanding task of packing the TV mounts makes sense intuitively, even if perhaps the sentiment may be somewhat politically incorrect.

Because we find that Petitioner did not prove her shoulder condition was caused by her work accident, the Commission vacates the Arbitrator's award of temporary total disability benefits, the award of medical expenses, and the award of prospective treatment for her shoulder. Respondent stipulated temporary total disability benefits through November 17, 2014, for a total of 13&4/7 weeks. The Commission finds that date a reasonable date to terminate such benefits. Dr. Murphy opined that Petitioner should be at maximum medical improvement for her wrist within six to eight weeks. While, we disagree with Dr. Murphy regarding the causation of Petitioner's elbow condition, it seems that Petitioner's elbow and wrist conditions improved more or less at the same rate.

Similarly, the Commission finds that Respondent is responsible for expenses associated with treatment of Petitioner's wrist and elbow but not her shoulder. The Commission finds that Respondent should be responsible for medical expenses incurred through November 12, 2014. On that date, and after about 16 therapy sessions, she reported to Dr. Dhutia consistently improving elbow and wrist conditions but consistent 8/10 shoulder pain. Petitioner reported she had no elbow pain and wrist pain was 80% better at 2/10. At that time, he ordered an MRI and apparently referred Petitioner to Dr. Silver for her shoulder. Dr. Silver acknowledged that he only treated Petitioner's shoulder. Therefore, the award of Dr. Silver's medical bills and the prospective shoulder surgery he recommended is vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $253.00 per week for a period of 13&4/7 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 compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for medical expenses incurred for treatment provided to Petitioner through November 12, 2014, pursuant to the medical fee schedule.

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.

18IWCC0308

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 $25,000.00. 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: MAY 18 2018

Deborah L. Simpson

Deborah L. Simpson

DLS/dw
O-3/22/18
46

Stephen J. Mathis

Stephen J. Mathis

Dissent

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety. The majority bases its decision on Petitioner's delay in reporting shoulder pain as well as inconsistencies in Petitioners reported mechanism of injury. With respect to Petitioner's initial medical treatment, although her primary complaints were regarding her left wrist and elbow, Petitioner did mention shoulder complaints. Petitioner began treatment with her shoulder physician, Dr. Silver, within three months of the date of accident. Dr. Silver opined that most people do not have an immediate onset of pain with rotator cuff impingement. Further, Dr. Silver opined causal connection between the accident and Petitioner's condition of ill being regarding her shoulder.

In regard to the inconsistencies relied upon by the majority, those inconsistencies are distinctions without a difference. Petitioner testified at hearing of just finishing the assembly of a wall mount weighing 50 pounds and lifting it to pack. Petitioner's medical records consistently indicate that she was lifting a part weighing 40 pounds. Petitioner's testimony of the mechanism of injury (lifting) was corroborated by the histories taken in her medical records, the only difference being the weight of the part (40 vs. 50 pounds) she lifted.

Petitioner's claim basically turns on credibility. Although the medical histories provided by Petitioner are consistent regarding the mechanism of injury and ongoing symptomology, there are minute inconsistencies with respect to the weight of the item she was lifting. The Arbitrator had the opportunity to observe the Petitioner's demeanor and hear Petitioner's testimony live, as well as the testimony of Respondent's witness. After hearing testimony, the arbitrator found Petitioner to be credible and Respondent's witness to be incredible. The Arbitrator provided an analysis of the inconsistencies and an explanation of her credibility findings. Ultimately, the basis of the majority's modification of the Arbitrator's decision is Petitioner's credibility or lack thereof. I would defer to the credibility finding of the trier of fact who had the opportunity to hear the Petitioner's testimony in person. Accordingly, I would affirm the Arbitrator's well-reasoned decision in its entirety.

David L. Gore

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0308

SIMENTAL, MARIBEL
Employee/Petitioner

Case# **14WC031101**

UNISTAFF INC
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:

4069 LAW OFFICE OF JONATHAN SCHLACK
CHRISTOPHER BASSMAJI
200 N LASALLE ST SUITE 2830
CHICAGO, IL 60601

0560 WIEDNER & McAULIFFE LTD
MICHAEL F DOERRIS
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0308

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

MARIBEL SIMENTAL
Employee/Petitioner

v.

UNISTAFF INC.
Employer/Respondent

Case # **14** WC **31101**

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 A. HEGARTY**, Arbitrator of the Commission, in the city of **WHEATON**, on **12/20/16**. 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 **8/12/14**, 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 **$10,995.20**; the average weekly wage was **$274.88**.

On the date of accident, Petitioner was **36** 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.

ORDER

- Petitioner is entitled to TTD benefits from August 14, 2014 through December 20, 2016, representing 122 and 5/7 weeks. Because Petitioner is at the statutory minimum TTD rate of $253.00, the Arbitrator orders Respondent to pay $31,046.71 to Petitioner ($253.00 x 122 & 5/7 Weeks).

- Petitioner was paid TTD from August 19, 2014 through November 17, 2014 representing 12 and 6/7 weeks at a rate of $183.25 resulting in an underpayment of $69.75 per week. This results in a total underpayment of $896.79 ($69.75 x 12 and 6/7 weeks). The Arbitrator orders Respondent to pay $896.79 to Petitioner for the underpayment of TTD benefits.

- Respondent is ordered to satisfy the following outstanding charges with respect to reasonable and necessary medical care subject to the limitations of the fee schedule:

Cadence Occupational Health	$576.05
Cadence Occupational Health PT	$950.52
Spinal Rehab and Wellness Center	$16,155.00
Naperville Medical Imaging	$1,926.00
Orthopedic Specialists of the North Shore	$2,729.00
New Life Medical Center.	$6,000.00
Rx Development	$17,799.33
Infinite Strategic Innovations.	$295.56

- Respondent is liable for the prospective left shoulder surgery as well as any post-surgical care prescribed by Dr. Silver, pursuant to the fee schedule.

- The petition for penalties/fees filed by Petitioner 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.

Jason C. Wright

Signature of Arbitrator

5/10/17
Date

ICArbDec p 2

MAY 10 2017

18IWCC0308

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIBEL SIMENTAL,	)	
	)	
Petitioner,	)	
	)	
	)	
vs.	)	**No. 14 WC 31101**
	)	
	)	
UNISTAFF,	)	
	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter proceeded to hearing in the city of Wheaton, Illinois, on December 20, 2016. (Arb. 1).

STATEMENT OF FACTS

Petitioner was employed by Respondent, a staffing agency, who sent her to work at "Peerless", where her job duties included assembling fifty (50) pound television wall mounts using a pneumatic screwdriver. When the wall mount was fully assembled, she would move the unit to the next station, a task that, according to Petitioner, required above shoulder lifting. (Id., at 9-12). On August 12, 2014, in this capacity, lifting a fully assembled wall mount above her shoulders, when she felt severe and immediate pain to her left wrist and left elbow. (Id. at 13-14). Petitioner testified that the pain was mostly at the left elbow and the left wrist with secondary pain in her left shoulder. (Id. at 18-19). She reported the accident to her supervisor, completed her shift, and continued to work for two days after the date of accident. (Id.).

On August 14, 2014, she filled out an accident report form and was sent by Respondent to the company clinic. (Id.).

The medical records from Cadence Occupational Health from August 14, 2014 note Petitioner's complaints of pain in her left wrist to her mid-bicep with associated tingling in the second and third digits of her left hand. (Pet. Ex. 1 at 7). Rasa McCarthy, MD, noted the injury occurred two days prior when Petitioner was lifting parts weighing 40 pounds at work when she noticed pain in the posterior left hand/wrist that extended up to the left elbow. (Id.). Petitioner was released with restrictions of no lifting, pulling, or pushing more than two pounds with the left hand and was instructed to wear a wrist brace. (Id. at 9).

On August 21, 2014, Petitioner followed up at Cadence Occupational Health with complaints of left wrist pain that intermittently radiated up to the left elbow and shoulder. (Id.). Dr. Adrienne Babinski, DO noted that Petitioner's pain in the left arm would increase with daily activities such as dressing or brushing her hair. (Id.). Petitioner was diagnosed with a left wrist sprain and left elbow lateral epicondylitis caused by work activities. (Id., at 17). Work restrictions were continued with instructions to begin occupational therapy which commenced on August 27, 2014 at Cadence Health. (Pet. Ex. 2, at 3). The therapy records from Cadence note that Petitioner began therapy on August 27, 2014 with a history of injury to her left wrist up to the

left elbow following an incident at work while lifting an item. (Id.). Petitioner reported that she was a TV part assembler who needed to lift 40-50 pounds. (Id. at 4). During an exercise involving the brachial plexus nerve glide on the right side, Petitioner was able to complete a full glide of 90 degree shoulder abduction, but on the left side Petitioner was only able to abduct 50 degrees. (Id., at 5). The therapist noted Petitioner was unable to perform the essential requirements of her job. (Id. at 6).

Petitioner followed up with Dr. Babinski on September 9, 2014, with complaints of sharp, throbbing pain in her left wrist. (Id.). Petitioner stated that therapy was actually hurting her. (Id.). An MRI of the left wrist and EMG of the left arm was recommended. (Id.).

On September 18, 2014, Petitioner consulted with Mira Dhutia, DC at Spinal Rehab and Wellness Center (a.k.a New Life Medical) where she reported a history of a work-related injury on August 12, 2014 while lifting a 50 lb. television base. (Pet. Ex. 4, at 5).

On September 22, 2014, Petitioner underwent a left wrist MRI, which revealed a small lunate cyst with adjacent reactive marrow edema, a minor negative ulnar variance as well as a cyst of the scaphoid bone. (Pet. Ex. 5, at 3).

On September 24, 2014, Petitioner followed up with Dr. Dhutia who noted a small left wrist cyst after review of the recent MRI. The doctor commented that the ulnar nerve impingement could be coming from the left elbow. (Pet. Ex. 4 at 6). Petitioner was to continue physical therapy. (Id.).

On October 1, 2014, Petitioner followed-up with Dr. Dhutia with complaints of increasing left elbow and shoulder pain. (Id., at 9). The doctor noted that since her work injury, pain had been traveling from Petitioner's left wrist to her left shoulder. Petitioner reported achiness in her shoulder accompanied by sharp pain with overhead reaching. (Id.). Dr. Dhutia noted that left shoulder treatment would be incorporated into therapy. (Id.).

Petitioner continued physical therapy from October 2 through October 22, 2014. During this time she reported constant and increased left shoulder pain. (Id.). A left shoulder MRI was recommended by Dr. Dhutia. (Id., at 19).

On October 24, 2014, an independent medical evaluation ("IME") at the request of Respondent with Dr. Brian Murphy was conducted. (Resp. Ex. 5). Dr. Murphy noted that Petitioner initially complained of pain in her left wrist and left elbow but now complained of left shoulder pain. (Id.). Petitioner complained of a burning, throbbing ache in her left shoulder and difficulty with activities at or above shoulder level. (Id.). On physical examination, Dr. Murphy noted Petitioner's inability to abduct beyond 90 degrees with positive Hawkins and Neer signs. (Id.). Dr. Murphy diagnosed Petitioner with a left wrist strain, left elbow medial epicondylitis, and left shoulder impingement syndrome. (Id.). Dr. Murphy opined that the accident could have accounted for the wrist sprain of the TFCC, but did believe a causal relationship existed between the work accident and Petitioner's left elbow or left shoulder conditions. (Id.). Dr. Murphy opined that Petitioner was not at MMI and would require further treatment for her left elbow and left shoulder including an MRI, further medical management, possible cortisone injections, and even surgery if all non-operative options were to fail. (Id.). Dr. Murphy dictated an addendum on November 12, 2014, noting that Petitioner could return to work in a limited duty for the left wrist with a five (5) pound restriction. (Id.).

On November 5, 2014, Petitioner underwent an MRI of the left shoulder which revealed bursitis of the subacromial/subdeltoid bursa overlying the distal/insertional supraspinatus and infraspinatus tendons. (Pet. Ex. 6, at 4-5)

On November 12, 2014, Petitioner followed up with Dr. Dhutia who referred her to an orthopedic specialist. (Id).

Petitioner continued to undergo physical therapy with Dr. Dhutia through July 16, 2015 with no new complaints or findings and was released from therapy on that date. (Id., at 27-65). During this time, Petitioner's left wrist and left elbow pain had improved although she continued to complain of persistent and severe pain in her left shoulder. (Id.).

On November 21, 2014, Petitioner presented for initial consult with Dr. Ronald Silver, at Orthopedic Specialists of the North Shore on referral from Dr. Dhutia. (Pet. Ex. 7, at 4). Dr. Silver noted that Petitioner was working as an assembler on August 12, 2014, lifting a heavy TV wall mount when she felt pain in her left shoulder, left wrist and left elbow. (Id.). Dr. Silver noted that prior to the work accident, she had no left shoulder symptoms or treatment. (Id.). On physical exam, tenderness at the rotator cuff insertion, anterolaterally, with positive impingement and Hawkins sign was noted. (Id.). Dr. Silver diagnosed Petitioner with rotator cuff impingement and administered a left shoulder subacromial cortisone injection. (Id.). Petitioner was to continue physical therapy and remain off-work. (Id. at 4-5 and 7).

On December 12, 2014, Dr. Silver noted Petitioner's report of temporary relief from the cortisone injection with pain returning after. (Pet. Ex. 7, at 8). On exam, impingement and Hawkins tests remained positive. (Id.). Dr. Silver opined that Petitioner would require left shoulder arthroscopic surgery. (Id.). Petitioner was to remain off-work and continue physical therapy to not lose any further motion or strength preoperatively. (Id., at 8-9).

Petitioner followed up with Dr. Silver on March 4, 2015, April 8, 2015, May 22, 2015, July 24, 2015, and August 29, 2015 with no new findings or complaints. (Pet. Ex. 7, at 14-26). Dr. Silver awaited authorization of his proposed left shoulder surgery. (Id.). Petitioner remained off work. (Id.).

Petitioner resumed physical therapy at New Life Medical Center with Dr. Snook on August 11 which continued through October 8, 2015. (Pet. Ex. 8, at 3).

Petitioner followed up with Dr. Silver on November 18, 2015, January 27, 2016, April 27, 2016, August 10, 2016, October 5, 2016, and November 30, 2016 with no new complaints or findings (Pet. Ex. 7, at 30-47). During this time Petitioner remained off work pending approval of the recommended surgery, which Dr. Silver continued to opine was causally related to her work injury of August 12, 2014. (Id.).

Petitioner testified that as of the day of trial, she remains under the care of Dr. Silver and wants to proceed with the surgery he recommended. (Tr. Trans, at 24-25). Petitioner continues to have pain in her left shoulder, which radiates up to the left side of her neck. (Id., at 26-27). Her pain affects activities of daily living such as cleaning around the house, lifting objects, and lifting her arm. (Id., at 27). She has been off-work since August 14, 2014. (Id., at 25). Petitioner testified that she has not had any new accidents or incidents since August 12, 2014. (Id., at 27). Prior to August 12, 2014, Petitioner did not experience any pain in her left wrist, left elbow, or her left shoulder nor did she treat with a medical doctor for such. (Id., at 27-28).

CONCLUSIONS OF LAW

(F),Whether Petitioner's current condition of ill-being is causally related to the injury

Petitioner sustained a compensable injury to her left wrist, left elbow and left shoulder as a result of the occurrence on August 12, 2014. The causal connection between Petitioner's current ill-being and her August 12, 2014 work accident is supported by the medical evidence and Petitioner's testimony.

Two days after the accident, Petitioner reported complaints of pain in her posterior left hand/wrist up to her left elbow that occurred *when lifting parts weighing 40 pounds at work.* The August 27, 2014 records from Cadence Occupational Health note complaints to the left wrist radiating up to the left elbow following an accident at work *involving lifting an item.* It was noted that Petitioner was an assembler that worked on TV parts, and she needed to lift 40-50 pounds.

On September 18, 2014 Mira Dhutia, DC noted that Petitioner sustained a work-related injury at work on August 12, 2014 when she was *lifting a TV base weighing about 50 pounds* when she felt a crack in her wrist and sharp pain thereafter.

Dr. Silver's records from November 21, 2014 noted a history of lifting a heavy TV mount when Petitioner felt pain in the left shoulder, wrist and elbow. The Arbitrator finds the aforementioned records corroborate Petitioner's testimony with respect to the mechanism of injury (i.e. that she was indeed lifting a heavy wall mount at the time of the accident).

With respect to Petitioner's left shoulder condition, the Arbitrator notes that nine (9) days after the accident, Petitioner reported to Cadence Occupational Health with complaints of left wrist pain that intermittently radiated up to the elbow and *up to the left shoulder.* (Id)

The Arbitrator adopts the opinions of Dr. Silver who noted no evidence of any pre-existing condition with regard to the left shoulder and that the mechanism of injury (lifting of a heavy television wall mount on August 12, 2014) is a competent cause of inflammation and damage to the left shoulder rotator cuff. (Pet. Ex. 11, at 16). Dr. Silver noted Petitioner had been working full time without restrictions prior to this accident. Dr. Silver explained that most people do not experience the immediate onset of rotator cuff impingement following a trauma. Instead, the condition often begins with a minor ache or pain in the shoulder that becomes symptomatic later in time due to progressive inflammation and swelling. (Id. at 17-18). Dr. Silver testified that Petitioner's left shoulder MRI revealed traumatic inflammation inconsistent with her age. (Id. at 39-40).

Pursuant to his IME, Dr. Murphy diagnosed Petitioner with a left wrist strain, left elbow medial epicondylitis, and left shoulder impingement syndrome. Dr. Murphy opined that these diagnoses are supported by objective findings as well as Petitioner's complaints. According to the doctor, the accident could have accounted for the wrist sprain of the TFCC, although he found no causal relationship between the work accident and Petitioner's left elbow and shoulder condition.

Dr. Murphy and Dr. Silver both agree that lifting an object weighing between 40-50 pounds could cause a strain of the rotator cuff

Dr. Dhutia opined that the left shoulder symptoms were causally related to the originally injury with a delayed onset of pain.

With respect to Mr. Hamilton's testimony, the Arbitrator notes multiple inconsistencies. Although he was adamant that Petitioner worked in sub assembly on the date of the accident and that she would not have to lift more than 15-25 pounds. The job description that Mr. Hamilton wrote stated that an assembler had to lift up to 50 pounds (Resp. Ex. 5, Ex. 7).

Further, he testified that Peerless would assemble television mounts in all sizes weighing up to 60-70 pounds. (Tr. Trans. at 76).

Mr. Hamilton testified that Petitioner never worked as a packer or in packaging, yet he listed her as a "Packer" on the Unistaff, Inc. Accident Investigation Report. (Resp. Ex. 11). With Respect to Respondent's Exhibit 11, Mr. Hamilton noted that Petitioner injured herself using the torque gun, however, earlier that day Petitioner completed a Minor Injury Report that stated she injured herself while lifting. (Resp. Ex. 3). Mr. Hamilton signed off on that document, but stated he did not know what the document said because it was in Spanish. (Trans. at 125).

This Arbitrator observed Petitioner closely during the hearing noting her calm demeanor. Petitioner's testimony was direct, cohesive and appeared sincere. The Arbitrator found her to be a credible witness at the hearing and notes that Petitioner's testimony is corroborated by the medical records.

In support of the Arbitrator's decision relating to (K), whether the Petitioner is entitled to Temporary Benefits pursuant to 19(b) of the Act, this Arbitrator finds the following:

Pursuant to the findings above, this Arbitrator finds Petitioner entitled to TTD benefits for the period of August 14, 2014 through December 20, 2016, representing 122 and 5/7 weeks. Further, this Arbitrator awards TTD benefits up until the hearing date pursuant to the Act.

In support, the Arbitrator notes from August 14, 2014 through September 15, 2014, Petitioner treated at Cadence Occupational Health. She was prescribed a left wrist brace and was restricted to no lifting, pulling, or pushing more than two pounds with the left hand. Respondent was unable to accommodate these restrictions. Petitioner then came under the care of Dr. Dhutia at Spinal Rehab and Wellness Center (a.k.a New Life Medical) from September 18, 2014 through July 16, 2015. Petitioner remained off work throughout the entirety of this treatment. On November 21, 2014, Petitioner came under the care of Dr. Ronald Silver, an orthopedic specialist and continued to treat with Dr. Silver through November 30, 2016. During this time, Petitioner remained off work pending left shoulder surgery approval, which Dr. Silver continued to opine was causally connected to her work injury of August 12, 2014.

As the medical records reflect and as Petitioner testified, she last worked for Respondent on August 14, 2014 and has not worked anywhere since. Petitioner has been consistently treating through the date of this trial and has been consistently off of work from August 14, 2014 through December 20, 2016. Further, Petitioner remains off work pending surgery as recommended by Dr. Silver. Petitioner has yet to undergo surgery due to lack of authorization, and therefore remains off work.

The Arbitrator notes the evidence related to Dr. Murphy who opined that Petitioner was not at MMI and would require further treatment to the left elbow and left shoulder including an MRI, further medical management, possible cortisone injections, and even surgery if all non-operative options were to fail. Dr. Murphy dictated an addendum on November 12, 2014, in which he opined Petitioner could return to work in a limited duty for the left wrist with a five (5) pound restriction. He concluded by stating Petitioner could return to work full duty within 6-8 weeks from the date of the accident for the left wrist and that any difficulty at work would likely be due to other diagnoses that are present.

It is well documented in the medical records that Petitioner's symptomology continued to worsen and become more severe since the date of accident. As noted above, Petitioner's left shoulder condition is causally related to her original work injury of August 12, 2014. After reviewing Petitioner's job description as an assembler, which in part required Petitioner to lift up to 50 pounds, Dr. Murphy opined that Petitioner could return to work if her left wrist condition had resolved. (Resp. Ex. 5, at 45-46, (Id., at 46). However, Dr. Murphy conceded that Petitioner's left elbow and left shoulder complaints made it "unlikely she would be able to participate in those types of activities". (Id.).

The Arbitrator finds the Petitioner is entitled to TTD benefits from August 14, 2014 through December 20, 2016. This Arbitrator finds that Respondent is liable for all related time periods and orders Respondent to pay benefits representing 122 and 5/7 weeks.

The parties agree that the average weekly wage is $274.88. Petitioner is married with no dependent children. Therefore, Petitioner is at the statutory minimum TTD rate of $253.00. The Arbitrator orders Respondent to pay $31,046.71 to Petitioner ($253.00 x 122 & 5/7 Weeks). Further, this Arbitrator awards TTD benefits from December 21, 2016 through the date of the hearing.

Finally, Petitioner was paid TTD from August 19, 2014 through November 17, 2014 representing 12 and 6/7 weeks at a rate of $183.25 resulting in an underpayment of $69.75 per week. This results in a total underpayment of $896.79 ($69.75 x 12 and 6/7 weeks). The Arbitrator orders Respondent to pay $896.79 to Petitioner for the underpayment of TTD benefits.

In support of the Arbitrator's decision relating to (J), whether medical treatment rendered was reasonable and necessary, this Arbitrator finds the following:

This Arbitrator finds the testimony of Petitioner and Petitioner's treating physicians credible and finds that the treatment to date has been reasonable and necessary. All of Petitioner's treating physicians have consistently noted in their medical records that all treatment rendered was due to the work-related injury of August 12, 2014. Therefore, this Arbitrator holds Respondent liable for all outstanding medical charges incurred thus far pursuant to the fee schedule. These charges are $576.05 to Cadence Occupational Health, $950.52 to Cadence Occupational Health PT, $16,155.00 to Spinal Rehab and Wellness Center, $1,926.00 to Naperville Imaging Center, $2,729.00 to Orthopedic Specialists of the North Shore, $6,000.00 to New Life Medical Center, $17,799.33 to Rx Development, and $295.56 to Infinite Strategic Innovations, subject to the limitations of the fee schedule.

In support of the Arbitrator's decision relating to (O), whether the prospective medical treatment recommended is reasonable and necessary, this Arbitrator finds the following:

Given the findings above, this Arbitrator finds the testimony of Petitioner and Petitioner's treating physicians credible and finds the prospective left shoulder surgery, as well as any post-surgical care prescribed by Dr. Silver, reasonable and necessary and orders Respondent to pay for such treatment pursuant to the fee schedule.

In support of the Arbitrator's decision relating the (M), whether penalties or fees should be imposed upon Respondent, this Arbitrator finds the following:

The Arbitrator does not find Respondent's reliance on Dr. Murphy's medical opinion so unreasonable as to justify an award of penalties or fees under the Act. Accordingly, Petitioner's request is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Petermeyer,

Petitioner,

18IWCC0309

vs.

NO: 09 WC 41291

Alberternst Construction,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court of Madison County. In a June 15, 2017 Order, the honorable David W. Dugan reversed the September 25, 2016 Decision of the Commission and remanded this case to the Commission with directions to reinstate the October 8, 2015 Decision and award of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015, which is attached hereto, is hereby reinstated in accordance with the Order of the circuit court dated June 15, 2017.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $201,839.34, as provided in Section 8(a) of the Act. Respondent shall be given a credit of $401,639.89 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.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $746.59/week for 140 2/7 weeks, commencing 6/3/08 through 2/8/11, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner maintenance benefits of $746.59/week for 63 1/7 weeks, commencing 2/9/11 through 4/24/12, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay

18IWCC0309

Petitioner permanent partial disability benefits of $636.15/week for 250 weeks, because the injuries sustained caused the 50% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner penalties of $9,428.37, as provided in Section 16 of the Act; and $23,570.92, as provided in Section 19(k) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: MAY 18 2018
DLS/plv
r-6/15/17
46

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

18IWCC0309

PETERMEYER, JEFF
Employee/Petitioner

Case# **09WC041291**

ALBERTERNST CONSTRUCTION INC
Employer/Respondent

On 10/8/2015, 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 0.06% 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:

4888 LAW OFFICE KEITH SHORT
1801 N MAIN
EDWARDSVILLE, IL 62025

2593 GANAN & SHAPIRO PC
HEATHER J RUSSO
411 HAMILTON BLOVD SUITE 1006
PEORIA, IL 61602

18IWCC0309

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

Jeff Petermeyer
Employee/Petitioner

v.

Alberternst Construction, Inc
Employer/Respondent

Case # **09 WC 041291**

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 **Collinsville**, on **2/19/2015**. 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 _____

18IWCC0309

FINDINGS

On **6/2/2008**, 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.

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 **$58,234.28**; the average weekly wage was **$1,119.89**.

On the date of accident, Petitioner was **44** 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 **$103,882.67** for TTD, **$N/A** for TPD, **$N/A** for maintenance. and **$401,639.89** for other benefits (medical), for a total credit of **$505,522.56**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $201,839.34, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $401,639.89 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $746.59/week for 140 2/7 weeks, commencing 6/3/08 through 2/8/11, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $746.59/week for 63 1/7 weeks, commencing 2/9/11 through 4/24/12, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $636.15/week for 250 weeks, because the injuries sustained caused the 50% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay to Petitioner penalties of **$9,428.37**, as provided in Section 16 of the Act; **$23,570.92**, as provided in Section 19(k) of the Act; and **$0**, 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.

Signature of Arbitrator

9/22/15
Date

ICArbDec p. 2

OCT - 8 2015

BACKGROUND

Petitioner injured his low back on June 2, 2008 while working for Respondent. Petitioner underwent posterior and anterior lumbar fusions from L3 to S1 on January 15, 2010 and February 5, 2010, respectively. This matter was arbitrated pursuant to §19(b) on June 28, 2010. The Petitioner established causation and was awarded medical expenses subject to the fee schedule as well as temporary total disability benefits for a period of 108 weeks, commencing on June 2, 2008, through June 28, 2010. The decisions of the Arbitrator and Commission are admitted as AX2 & AX3. This matter was then tried on February 19, 2015. The issues in dispute are causation, future medical expenses, TTD, maintenance, nature and extent, and penalties.

FINDINGS OF FACT

Following the §19(b) hearing Petitioner has continued to treat with Dr. Taylor, an orthopedic surgeon, and Dr. Granberg of Millennium Pain Management. Dr. Taylor referred Petitioner to physical therapy post operatively, beginning June 14, 2010 and extending through January 31, 2011. (Px. 8).

Petitioner saw Dr. Granberg, every 2-3 months throughout 2011 and 2012. (Px. 5). Beginning with the June 19, 2012 visit, Petitioner reported increasing pain in his back for which Dr. Granberg offered a trial bilateral sacroiliac joint injection and trigger point injection in the lumbar paraspinous muscles above the level of his fusion. (Px. 5, pp. 314-15). The injections were performed on June 19, 2012 by Dr. Granberg. (Px. 5, pp. 316-17). Petitioner reported some relief from the injections and continued to receive medications from Dr. Granberg. (Px. 5, pp. 318-28). On January 3, 2013, Petitioner's medications were altered with the addition of Gabapentin to his Percocet regimen. The record noted he was previously able to go three months between visits but was having to be seen more frequently. (Px. 5, pp. 329-31). Second bilateral sacroiliac joint injection and trigger point injections were performed May 31, 2013. (Px. 5, pp. 338-42). Again, at the next visit on June 28, 2013, Petitioner reported 80% relief from the injection although he only reported 65% relief from medications. (Px. 5, pp. 343-45). On July 26, 2013, his Percocet dosage was increased. (Px. 5, pp.346-48). Additional trigger point and sacroiliac joint injections were performed on October 7, 2013 and December 30, 2013. (Px. 5, pp. 352-56; 363-67). Injections continued to be performed throughout 2014 in February, April, June, July, September and most recently December 2014. (Px. 5).

On February 8, 2011, Dr. Taylor found Petitioner at maximum medical improvement and deferred future pain treatment to Dr. Granberg. (Px 1, p. 51). The doctor indicated Petitioner could perform in the medium job demand level, however it reportedly caused increased symptoms of back pain and therefore Dr. Taylor recommended light demand activity as more reasonable. (Px. 1, pp. 50-51). At that time, Dr. Taylor placed "social restrictions" of frequent lifting up to 10 pounds, occasional bending, kneeling, crawling, squatting, reaching overhead, reaching above shoulders; frequent sitting, standing, walking; occasional climbing stairs, and then limited vibration, grasping, repetitive motion. (Px. 1, p. 52). Dr. Taylor's testified that as of February 8, 2011 Petitioner had a permanent restriction of duties in the "light demand level." (Px. 1, p. 53). Dr. Taylor testified the functional capacity evaluation was aligned with what he had given Petitioner in terms of permanent restrictions. (Px. 1, p. 54). Dr. Taylor did not note any signs of malingering or somatization as a significant component to Petitioner's presentation during his treatment. (Px. 1, pp. 54-55). At the time of his April 17, 2013 deposition, Dr. Taylor indicated no further surgical treatment was required and Petitioner's medical treatment moving forward would be pain management, although he would defer to Dr. Granberg with respect to any future pain management. (Px. 1, p. 57; 61). In Dr. Taylor's opinion, the medical care provided to Petitioner

has all been related to the original work injury. (Px. 1, p. 58). In his medical record of June 26, 2012, as well as those of November 2, 2012 and April 9, 2013, Dr. Taylor reiterated Petitioner could work within the light duty level. (Px. 3, pp. 162-64; Px. 2, p. 157). When Dr. Taylor saw Petitioner on November 2, 2012, he reported hip pain and groin pain increased with activity and improvement of some pain symptoms following sacroiliac joint injection performed by Dr. Granberg on June 19, 2012. (Px. 1, pp. 59, 61; Px. 5, pp. 314-17).

On December 24, 2012, an FCE was performed at Apex Physical Therapy which noted Petitioner could function at least at the light duty level. (Rx. 7, p. 119).

The next time Dr. Taylor saw Petitioner following November 2, 2012, was on July 16, 2014. (Px. 3; Px. 2, pp. 112-13). On April 9, 2013 Dr. Taylor again indicated Petitioner was capable of performing light duty demand level work. (Px. 2, p. 112; 154). When Dr. Taylor saw Petitioner on July 16, 2014, Petitioner reported his symptoms were significantly worse and reported being markedly limited by his pain symptoms. (Px. 2, p. 115). Petitioner reported his pain medications were providing him with little relief although he did obtain short term improvement after injections from Dr. Granberg. (Px. 2, p. 115). Dr. Taylor's examination findings were substantially similar to the physical findings noted at the November visit. Dr. Taylor testified this is consistent with SI joint pathology bilaterally. (Px. 2, p. 116). An EMG conducted by Dr. Phillips on July 16, 2014 was negative. (Px. 6). Dr. Taylor diagnosed Petitioner with end stage failed back syndrome due to both SI joint and L2-3 adjacent segment issues. (Px. 2, p. 117). Dr. Taylor testified he determined that Petitioner's back condition had deteriorated as of July 16, 2014, based on Petitioner's subjective complaints of pain and the relief Petitioner reported to him from the injections performed by Dr. Granberg. (Px. 1, p. 134). Dr. Taylor testified he denotes "social restrictions" separate from work restrictions. (Px. 1, p. 137). Dr. Taylor placed a work restriction that Petitioner was unemployable based on worsening symptoms. (Px. 2, p. 120). Dr. Taylor also placed sedentary social restrictions indicating lifting at a maximum of 5 pounds, limited bending, kneeling, crawling, squatting, working overhead or reaching above shoulder level. (Px. 2, p. 156). Dr. Taylor indicated he used the term "unemployable" because he felt his overall prognosis would be best if he was not in the work environment, but it does not delineate any physical restrictions. (Px. 1, p. 138). Socially, Dr. Taylor felt Petitioner could function at the sedentary level. (Px. 1, p. 138). Dr. Taylor further indicated the basis for the change in work status between April 2013 and July 2014 was primarily Petitioner's subjective report of symptoms and the description Petitioner gave of his capabilities and limitations. (Px. 2, pp. 139, 142). Dr. Taylor conceded he is not an expert in vocational rehabilitation. (Px. 1, p. 138).

With regard to further treatment, Dr. Taylor testified that as a last resort there is an operation which is extremely morbid and includes extending the fusion into the thoracic spine and past the SI joint into the sacrum, essentially locking the sacrum or pelvis to the thoracic spine. (Px. 2, p. 121). Dr. Taylor does not actually have any plans to perform this procedure on Petitioner. (Px. 2, p. 122). At this point, Dr. Taylor is not recommending Petitioner have the additional fusion procedure. (Px. 1, p. 128). Dr. Taylor has not seen Petitioner again since his July 16, 2014 visit. (Px. 2, p. 128).

Dr. R. Peter Mirkin saw Petitioner pursuant to §12. Dr. Mirkin initially saw Petitioner prior to the 19(b) hearing, on February 9, 2009 with addendums dated July 23, 2009 and April 26, 2010. (Rx. 4). Dr. Mirkin performed another §12 examination on October 24, 2014. He was deposed on November 21, 2014. (Rx. 2; Rx. 1). Dr. Mirkin testified at the time of the independent medical examination Petitioner reported he was doing better than before the surgery, was taking four Oxycodone per day but had complaints of pain in his back and numbness in his legs. (Rx. 1, pp. 8-9). Dr. Mirkin noted positive Waddell sign due to Petitioner's complaint of

pain when he only lightly touched his back. (Rx. 1, p. 10). Petitioner was noted to have 70% range of motion, forward flexion within 15 inches of touching his fingers to the floor, ability to walk on his heels and toes, squat and rise from the squat position, negative straight leg raise test and intact motor and sensory examination. (Rx. 1, p. 10). Dr. Mirkin reviewed x-rays taken in his office which showed an intact fusion with hardware in place from L3 to S1 with the disc above the fusion appearing normal. (Rx. 1, p. 11). Dr. Mirkin agreed with the functional capacity evaluation conducted in October 2012 indicating Petitioner could work at least in the light demand capacity. (Rx. 1, p. 11). In Dr. Mirkin's opinion, there was nothing to indicate progressive pathology of the spine. (Rx. 1, p. 12). Additionally, Dr. Mirkin saw no indication for further surgical procedure as there were no physical findings which supported further surgeries. (Rx. 1, pp. 12-13). Dr. Mirkin noted Petitioner had mild subjective findings and the only objective finding was that he had a prior fusion visible via hardware. (Rx. 1, p. 13). Dr. Mirkin was aware Petitioner was able to, and did work following surgery, and therefore, in his opinion, is employable in some capacity. (Rx. 1, p. 20). Further, in Dr. Mirkin's opinion, Petitioner does not need ongoing medications or a pain specialist. (Rx. 1, p. 37).

Petitioner testified he improved after the surgery and then started declining. In 2011 and early 2012, he began developing hip pain and pain radiating into his legs. In order to do yard work, he utilizes a riding lawn mower, but mostly has his wife and son perform such tasks. (T. 20; 41).

Petitioner completed high school and went to trade school for refrigeration, heating and cooling and also has a degree in construction management from Belleville Area College, now SWIC. Petitioner indicated he did a job search following his release to light duty in 2011 which was marked Petitioner's Ex. 15. He testified he looked for jobs in the construction field because that was all he knew, having worked at Albertemst Construction since the age of 18. Petitioner participated in vocational rehabilitation provided by Respondent. Respondent's counselor first met with Petitioner on March 15, 2012. He indicated there after he was rarely contacted by the vocational counselor and when they did connect it was at times favorable to her. He further testified the vocational counselor provided him a resume which he sent to a few people, only one of which responded, but did not offer him employment. He did not inquire at any residential construction jobs in St. Louis. Petitioner testified he followed up with every lead the vocational rehabilitation counselor sent. Petitioner testified he did not recall the vocational counselor discussing a vocational rehabilitation plan with him. Petitioner testified that in April 2012 he was on light duty, could not tolerate a lot of bending, and lifting anything caused pain or soreness for the next few days.

In 2012 Petitioner worked for a friend who was building a house. His duties included obtaining permits, helping with blueprints, organizing workers and going to the construction site to make sure they were doing the job. (Px. 4; Rx. 10). He did no manual labor. His job duties while working construction management for his friend also included opening and closing the job site as well as supervising what was done throughout the day. (T. 32-33). He could not check anything outside, walk on uneven ground or climb up a ladder to the attic. Petitioner testified he worked between 10 and 30 hours a week in construction management for his friend.

Petitioner also helped his brother-in-law with courier deliveries but he did not pursue that further after working there for approximately a year because he would only deliver smaller items and most of the items they delivered were heavier than 15 pounds, which was his lifting limitation at the time. He assisted with deliveries from May 2012 until late of 2013

Petitioner last actually looked for full time employment at the end of 2012 when he began receiving Social Security Disability. Petitioner testified he would be willing to try to work if there was a job available within his restrictions. Petitioner testified he could not stoop/squat. (T. 58). He testified anything with vibration takes its toll. He avoids bending at the waist, crouching or kneeling and walking over uneven surfaces. (T. 59; Px. 4). He has more functional capability earlier in the day. (Px. 4, p. 215).

Petitioner testified he received changes in his restrictions by Dr. Taylor in 2014. In July 2014 he was placed on a lifting restriction of 5 pounds and told to remain sedentary. Petitioner testified he is limited in terms of functional abilities. He can sit in a comfortable chair for maybe a half hour but then he needs to stand or lie in bed. He can't do much bending, stooping or picking things up. He does not do any yard work now, although he did in 2012. His wife does most of the mowing.

Respondent hired investigators to conduct surveillance of Petitioner. Surveillance was conducted for three days, on August 18, 2014, August 19, 2014 and August 20, 2014. On August 19, 2014, Petitioner was observed and recorded utilizing a leaf blower on the exterior of his home. This went on for approximately 3 to 4 minutes. (Rx, 12). The Arbitrator notes leaf blower did not appear heavy and Petitioner moved at a leisurely pace. That days surveillance showed nothing else of any significance. On August 20, 2014, Respondent's investigator obtained surveillance video of Petitioner from his home to a retail shopping plaza in St. Louis, MO. Petitioner's young niece had been in a minor motor vehicle accident and Petitioner traveled to the scene to assist his brother in law who was trying to repair the girl's vehicle enough that it could be driven home. Petitioner is seen putting gasoline in his truck and cleaning the windows. He is next seen handing tools to his brother-in-law and watching him attempt to make repairs to the vehicle's side-panels. Petitioner is seen using a small power screw driver and lightly pulling a few times on the side panel. He bends and kneels a few times to watch the other man work. The Arbitrator notes the tools do not appear to weigh more than his doctor's limitations. Petitioner is not seen lifting, pulling or pushing more than the few times. Respondent's investigator, Mr. Miller, acknowledged that the total amount of time Petitioner is seen using or handing small hand tools to the other man was about 3 minutes and that he actually used tools for approximately 2 minutes. Mr. Miller agreed that for the vast majority of the video on the 20th Petitioner is simply standing watching someone else work. The Arbitrator finds this to be an accurate description. Finally, the Arbitrator notes that in three days of surveillance Petitioner is seen actually engaged in about 4 to 6 minutes of activity, none of which appears to exceed the restrictions given by Dr. Taylor.

Petitioner retained vocational expert, Stephen Dolan. Mr. Dolan has a bachelor's degree, a Master's in American and English Literature, and took one graduate level coursework in Rehabilitation Counseling. (Px 4, p 196-7; 244). He is a certified rehabilitation counselor. (Px 4, p. 244). Mr. Dolan testified he met with Petitioner once on December 8, 2011 and then spoke to him one time after that on April 8, 2014. (Px. 4, p. 229). Petitioner had a number of transferrable job skills, excellent job history and qualities which Mr. Dolan indicated were beneficial to a prospective employer. (Px. 4, pp. 229-30). Mr. Dolan did not perform a labor market survey because, in his opinion, it was unnecessary due to what he termed "Petitioner's pain problem". (Px. 4, p. 230). Mr. Dolan documented Petitioner's educational history which was significant for graduation from high school, training at a technical school in the St. Louis area and Belleville Area College, where he obtained a certificate in construction management. (Px. 4, p. 206).

Mr. Dolan indicated Petitioner worked in 2011 as a construction consultant in building a new house which was quite large and also worked part time for a company called DZ Trucking as a courier. (Px. 4, p. 208).

Mr. Dolan testified Petitioner discontinued his work activities because they were exacerbating his pain problem. (Px. 4, pp. 208-09). Mr. Dolan reported Petitioner described limitations of being able to sit comfortably for only 10 to 15 minutes before having to change positions; standing for one hour, so long as he can move around; walking for 1.5 miles, although not on rough ground or on a slope; avoiding bending at the waist due to pain; and inability to crouch/squat or kneel. Furthermore, in terms of functional limitations, Petitioner can push and pull lightly, although not with force, and has to keep his low back out of any pushing or pulling. (Px. 1, pp. 213-14). Petitioner gave Mr. Dolan a list of companies he was familiar with from his work at Respondent which he had contacted about employment, but indicated no one was interested. (Px. 1, pp. 220-22). Mr. Dolan is of the opinion that Petitioner is not able to be gainfully employed in any regular and continuous marketplace due to his "pain problem" which requires Petitioner to take prescription pain medication. (Px. 4, pp. 225-26). Mr. Dolan agreed that Petitioner did a number of things as a construction manager which are within the light duty demand level. Those include reading blueprints, allocating manpower, budgeting, and the permitting process. (Px. 1, p. 228). However, Mr. Dolan testified his transferrable skills such as reading blueprints did not make him qualified for any job within the construction environment. (Px. 1, p. 231). Mr. Dolan determined Petitioner is not able to tolerate a regular work schedule, eight hours per day, five days per week due to his poorly controlled pain. (Px. 4, p. 254).

Respondent retained Brenda Latham to provide vocational rehabilitation services to Petitioner. Ms. Latham initially met with Petitioner on March 15, 2012. At that time, Petitioner was working as a construction manager on a new home being built by a friend. He spent approximately 20 hours weekly on the job site supervising and inspecting the work. He also assisted his brother in law as a contract delivery driver for which he usually got called once weekly. Ms. Latham reviewed Petitioner's list of employers he had contacted between April 2011 and January 2012. (Px. 15). Petitioner indicated most employers told him business was "too slow" or work would exceed his physical capabilities. Ms. Latham discussed possible jobs in construction management, "light" driving jobs, security/gate guard work, and sales of construction related equipment with Petitioner. Ms. Latham obtained job leads for Petitioner which she forwarded to him. On March 19, 2012, she provided two job leads for sales associates at Home Depot and transporter positions with Hertz Rent a Car. On March 26, 2012, she provided a lead for a part time insurance inspector. (Rx. 10, p. 150). On April 2, 2012, Petitioner responded to Ms. Latham indicating he had acted on four job leads. Ms. Latham identified additional leads for deck and fence services on April 3, 2012. On April 19, 2012, Ms. Latham provided additional job leads and developed a vocational rehabilitation plan. (Rx. 10, p. 151). Ms. Latham noted she was unable to complete a face to face meeting with Petitioner since the initial meeting on March 15, 2012 due to difficulties in reaching him by phone/email and scheduling conflicts. (Rx. 10, p. 151). On April 24, 2012, Ms. Latham met with Petitioner to review job placement services, at which time they reviewed the rehabilitation plan. (Rx. 10, p. 153). Petitioner indicated he was agreeable to the job goals but requested Ms. Latham to set up appointments with potential employers, as he did not want to "run around" to employers because he was not receiving any benefits. (Rx 10, p. 153-54). It was Ms. Latham's opinion that as of April 24, 2012. Petitioner refused to comply with the vocational rehabilitation plan which required him to contact at least 10 employers per week either via phone, mailing a resume, or by online application. (Rx 10, p. 153-54). On May 18, 2012, Ms. Latham wrote to Petitioner indicating that since he had not provided employer contact records indicating whether or not he was following up on job leads she wished to know whether he was still interested in job placement assistance and reminded him regular contact would be needed to coordinate vocational services. (Rx. 10, p. 156).

Respondent called Kelly Burger to testify at the arbitration hearing. Ms. Burger is a vocational case manager with a bachelor's degree in communications, a master's degree in vocational rehabilitation counseling, and has been a certified rehabilitation counselor since 2007. (T. 110). She reviewed Mr. Dolan's vocational rehabilitation evaluation and various medical records. (Rx. 8, 9). She also reviewed and relied upon the initial vocational evaluation from Brenda Latham, dated March 22, 2012, and her two progress reports dated April 19, 2012 and April 30, 2012. (T. 111). She did not meet with Petitioner. Ms. Burger testified Petitioner has an excellent work history which included supervisory and customer service skills which were transferrable to several light and sedentary positions. (T. 117; Rx. 8, p 134). She conducted a labor market survey which revealed 15 companies, all contacted between August 22, 2014 and August 26, 2014. (Rx. 9). Ten of these 15 companies indicated they were currently hiring or were hiring within the last month. Based on this totality of information, Ms. Burger concluded there was a potential labor market for Petitioner with positions within his work restrictions. She indicated Petitioner is employable in light or sedentary positions including but not limited to: supervisor/manager, supply clerk, inspector, dispatcher, customer service representative, telephone solicitor, chauffeur, front desk clerk, sale representative, hotel clerk, security/surveillance monitor, cashier, host, file clerk, parking lot attendant, bus monitor, office clerk, or light assembly/production. (Rx. 8, p 134). Although Ms. Burger was not aware of the July 16, 2014 restriction of Dr. Taylor to purely sedentary jobs, she testified this would not change her opinion because there are a multitude of factors beyond simply current medical status which she considers when determining employability. (T. 121-22; 128-29). Ms. Burger concluded Petitioner was not motivated to look for employment or participate in job search activities based on his conduct during the vocational rehabilitation efforts conducted in early 2012. (T. 114).

Petitioner was paid temporary total disability benefits by Respondent from the date of accident, June 2, 2008, through February 8, 2011. (Rx 6, p. 104-06).

CONCLUSIONS OF LAW

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

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 only issue in dispute regarding causal connection is related to future medical treatment. There was future surgery discussed by Dr. Taylor, however that surgery has not been recommended at this time and therefore is not ripe for consideration. Furthermore, Respondent did not place any other causal connection issues in dispute. Further, Respondent does not dispute the reasonableness or necessity of any treatment provided prior to the date of this hearing. As indicated above, since no treatment has been recommended as of this time, the question of the reasonableness and necessity of any potential prospective medical treatment is not ripe for consideration at this time.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the accident. The respondent shall pay $201,839.34 for medical services, as set forth in Petitioner's exhibits 9 - 14 pursuant to Section 8(a) 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 Petitioner. 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. The Arbitrator notes that the parties stipulated that Respondent is entitled to a credit of $401,639.89 for medical bills that have been paid. This amount however includes amounts paid for treatment both before and after the earlier 19(b) hearing.

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

The parties stipulated that Petitioner is entitled to temporary total disability benefits for the period of 6/3/08 through 2/8/11. Respondent terminated benefits following 2/8/11. Thereafter Respondent denies that Petitioner is entitled to any temporary benefits.

On 2/8/11 Dr. Taylor placed Petitioner at MMI. However, Petitioner was not released to his former employment and had significant restrictions that precluded a return to construction. Petitioner has proved that he was incapable of returning to his former employment. He remained disabled and his restrictions have gone from light duty to sedentary duty. Petitioner did conduct a job search following his release but was unable to locate work on his own. Respondent paid no benefits and offered no vocational rehabilitation services. There was no medical opinion contrary to that of Dr. Taylor at that time. Respondent did not have Petitioner re-examined by Dr. Mirkin until 10/24/14. Despite the fact that Petitioner was clearly incapable of returning to his former employment, Respondent did not provide vocational rehabilitation services until Ms. Latham met with Petitioner on 3/15/12. Petitioner initially cooperated with the limited vocational assistance he was provided by Respondent from 3/15/12 through 5/18/12. He eventually became difficult to contact and failed to comply fully with the vocational services provided. As of April 24, 2012, Petitioner was non-compliant as he refused to agree to contact at least ten employers per week via various means.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to temporary total disability benefits of $746.59 per week for 140 2/7 weeks, commencing 6/3/08 through 2/8/11, as provided in Section 8(b) of the Act. The Arbitrator further finds Petitioner is entitled to maintenance benefits of $746.59 per week for 63 1/7 weeks, commencing 2/9/11 through 4/24/12, as provided in Section 8(a) of the Act.

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

Petitioner seeks a finding of odd lot permanent total disability. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Comm'n,* 77 Ill.2d 482, 487 (1979). A claimant can establish entitlement to permanent total disability benefits under the Act in one of three ways: by a preponderance of the medical evidence; by showing a diligent but unsuccessful job search; or by demonstrating that, because of age, training, education, experience, and condition, there are no available jobs for a person in claimant's circumstance. *Federal Marine Terminals Inc. v. Illinois Workers' Compensation Comm'n,* 371 Ill.App.3d 1117, 1129 (2007). If claimant's disability is limited in nature so 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 circumstance. A claimant can satisfy the burden of proving 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. *Alano v. Industrial Comm'n,* 282 Ill.App. 3d 531, 534 (1996). Once a

claimant meets his burden of proving he falls into the "odd lot" category, the burden then shifts to the employer to prove the claimant is employable in a stable labor market and that such market exists. *Waldorf Corp. v. Industrial Comm'n*, 303 Ill.App.3d 477, 484 (1999).

Petitioner has failed to meet his burden of proving he falls into the permanent total disability category through a preponderance of the medical evidence. Dr. Taylor placed light duty restrictions on Petitioner as of the date of MMI, February 8, 2011. Since that date, the only basis for a change in Petitioner's restrictions were subjective complaints to Dr. Taylor and to Dr. Granberg. There was little change in the physical examination findings, radiographic studies or any objective findings either by Dr. Taylor or by Dr. Granberg. Although Dr. Taylor testified Petitioner's work status was "unemployable," he admitted that Petitioner was capable of work at the light demand level, in line with the FCE performed October 24, 2012.

Dr. Mirkin testified he saw no physical findings to support restrictions beyond the light demand level and specifically that there had been no changes he last examined Petitioner. The Arbitrator finds Dr. Taylor's testimony regarding Petitioner being unemployable in terms of work status yet having sedentary "social" restrictions less persuasive than that of Dr. Mirkin in this regard. If Petitioner is able to function socially at a sedentary level, certainly he is capable of working at least at a sedentary level. Work at the light or sedentary level is in line with the recommendations and opinions of Respondent's vocational rehabilitation counselor as well as the FCE performed in October 2012.

Petitioner has failed to meet his burden of proving he falls into the odd-lot category because he has failed to show either diligent but unsuccessful attempts to find work, or, that because of his age, skills, training, and work history he is not be regularly employable in a stable labor market. Although Petitioner did engage in a limited search for employment, the Arbitrator finds that Petitioner did not engage in diligent attempts to find work. Petitioner indicated he had contacted some companies with which he was familiar from his work for Respondent, but he could provide no documentation of jobs for which he applied. Petitioner's testimony established that he did not even look for work after he started receiving Social Security Disability benefits in late 2012. Petitioner's lack of diligent job search effort is also well-documented in the reports of Respondent's vocational rehabilitation experts, Kelly Burger, and Brenda Latham. Ms. Burger testified Petitioner did not give full effort to the vocational rehabilitation services provided by the Respondent from March 15, 2012 through May 18, 2012 and Petitioner refused to follow the vocational rehabilitation plan of at least ten employer contacts per week.

Mr. Dolan's testimony established Petitioner's excellent transferrable skills, education, training and work history. Petitioner has training and experience in computer software applications including Word and Excel, as well as supervisory and customer service skills which are transferrable to several light or sedentary positions. He has a high school degree, an associate degree in HVAC, and a certificate in construction management. He has a solid work history throughout his adult life. All of these skills are transferrable to light or sedentary work. Although Mr. Dolan testified due to Petitioner's self-described functional limitations he cannot tolerate a full work day, there is no medical evidence to support this assertion. Mr. Dolan did not perform a labor market survey and did not appear to base his vocational opinions on the variety of favorable factors he identified, including transferrable skills and education, but rather relied more on what he described as a "pain problem." Respondent's vocational rehabilitation expert, Ms, Burger, opined that Petitioner is employable at the light to sedentary duty level. The Arbitrator further notes this is in line with the social restrictions placed by Dr. Taylor. The Arbitrator finds the opinions of Ms. Burger more persuasive.

Petitioner points to the inability of vocational services provided by Respondent to secure him employment as support for his position he should be found to fall in the odd-lot permanent total disability category. The Arbitrator finds that the inability to obtain employment during vocational services was due, at least in part, to Petitioner's lack of diligent compliance with the vocational services provided.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has not met his burden of proving he falls into the odd-lot permanent total disability category.

While the possibility exists that Petitioner may have suffered some diminishment of earning capacity which may have entitled him to a wage differential award, the record in this case contains no evidence from which the amount of any such award could be determined.

Based on his medical treatment and his permanent restrictions, the Arbitrator finds Petitioner has proven he suffered a permanent partial disability of 50% loss of his body as a whole, for a total of 250 weeks.

Issue (M) Should penalties or fees be imposed upon Respondent?

On 2/8/11 Dr. Taylor had placed Petitioner at MMI. Petitioner was not released to his former employment. At no time was Petitioner released to return to full duty employment yet TTD stopped when Petitioner reached MMI. Respondent was well aware of significant restrictions that precluded a return to construction. Petitioner has proved that he was incapable of returning to his former employment. Petitioner conducted a job search following his release but was unable to locate work on his own. Respondent paid no benefits and offered no vocational rehabilitation services. There was no medical opinion contrary to that of Dr. Taylor at that time. Respondent did not have Petitioner re-examined by Dr. Mirkin until 10/24/14. Despite the fact that Petitioner was clearly incapable of returning to his former employment, Respondent did not provide vocational rehabilitation services until Ms. Latham met with Petitioner on 3/15/12. Still Respondent paid no maintenance benefits. The Arbitrator previously found Petitioner is entitled to maintenance benefits of $746.59 per week for 63 1/7 weeks, commencing 2/9/11 through 4/24/12, a total of $47,141.83. Respondent has offered no plausible excuse for its failure to offer vocational rehabilitation or pay maintenance benefits for over one year from the date of MMI to 3/15/12. Even after vocational rehabilitation was initiated Respondent persisted in its failure to pay maintenance benefits.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent's refusal to pay maintenance benefits beginning 2/9/11 was vexatious and unreasonable. Respondent shall pay penalties of $23,570.92 pursuant to section 19(k) and attorney's fees of $9,428.37 pursuant to section 16.

STATE OF ILLINOIS)
) SS
COUNTY OF LASALLE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marcy M. Faber,
Petitioner,

vs. NO. 08 WC 22105
(14 IWCC 0707)

State of Illinois/Mendota.,
Respondent.

ORDER

Petition for Penalties and Attorney fees under §19(k), §19(l), & §16, and the case having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner Gore on multiple occasions and finally heard May 19, 2017, in Ottawa, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premise finds:

1. This matter was timely and properly filed before the Commission for an accident date December 11, 2007, which arose out of and in the course of employment.

2. This matter came for hearing before Arbitrator Falcioni on December 27, 2012. The Arbitrator filed the decision February 5, 2013, wherein the Arbitrator awarded medical expenses of $22,802.10 with Respondent receiving credit for bills paid, as well as, a permanent partial disability award of 13.5% loss of use of the right arm. A Review was filed by both parties. The Commission affirmed the amount of permanent disability but modified the medical expenses award to $5,003.00 subject to the fee schedule and subject to credit of $3,794.49 for payments made to providers by Respondent. Commission decision filed August 21, 2014. The Commission decision ordered Respondent to pay to Petitioner the medical expenses awarded.

3. On September 29, 2014, Respondent tendered payment of the permanency award found by the Commission with no payments to Petitioner regarding the medical award. Thereafter, Petitioner's counsel made attempts to secure payment from Respondent regarding the medical expense award and as of December 30, 2014 found neither payment was tendered to Petitioner nor to those medical providers.

4. Petitioner filed their Petition for Penalties and attorney fees December 30, 2014 which initially came before the Commission January 16, 2015 and the matter had been continued multiple times until the ultimate hearing of this Petition May 19, 2017.

5. Petitioner argued that the medical expenses had been in dispute and awarded to Petitioner and Respondent was ordered to pay that to Petitioner for Petitioner's attorney to then pay those providers, being entitled to fees on the moneys awarded. Petitioner indicated Respondent had no authority to withhold that medical expense award and negotiate and pay those providers directly as the matter had been tried. Petitioner stated Respondent essentially tries to reserve a right to negotiate the bills and pay less than what was ordered and mandated under the law. Petitioner was awarded the medical expenses to satisfy the providers, as they sought to. Petitioner also noted the unreasonable delay in Respondent paying the bills (as awarded) promptly. Petitioner requested penalties and attorney fees

6. Respondent's attorney argued the penalty petition was not timely. Respondent argued the medical bills were disputed and the Commission modified the medical expenses award only reducing the amounts due Dr. Barrett. Respondent argued their obligation begins and ends with payment of the bills regardless of if those were paid directly to the provider per the fee schedule or tendering the money to Petitioner/Petitioner's counsel. Respondent stated Petitioner did not object when Respondent paid the bills directly prior. Respondent stated the Arbitrator did not order the bills to be paid to Petitioner but rather simply the bills were to be paid and Petitioner had time to object to the bills being paid to providers in 2015. Respondent noted the financial condition of the State and penalties and attorney fees should not be assessed when the State does not have funds to pay. Respondent stated payment of the bills did not violate Section 16 or 21 of the Act. Respondent argued the purpose of awarding medical bills was to make Petitioner whole and not an opportunity for Petitioner to inflate the permanency award (by Petitioner negotiating the bills down) and Petitioner's counsel to increase his fee on that. Respondent requested the Commission deny Petitioner's motion for penalties and attorney fees.

The Commission notes that Petitioner's initial petition was filed timely in December 2014 and the delay in pursuing the petition was due to Petitioner's counsel leaving the firm.

The Commission notes that the Order section of the Arbitrator's decision states that Respondent 'shall pay reasonable and necessary medical services…' and the discussion section notes that Petitioner was entitled to the medical expenses. Clearly, bills were disputed and at issue at hearing and Petitioner Counsel was successful in obtaining those expenses via the hearing and entitled to fees on that portion of the award. Both parties brought the matter on Review and the Commission modified the medical expenses award relative to bills of Dr. Barrett (chiropractic bills only to the time of Respondent's examiner). The Commission order stated, "It is therefore ordered by the Commission that Respondent pay to Petitioner the sum of $5,003.00 for the medical bills" … subject to credit of $3,794.49 (net medical expenses awarded $1,208.51). The

Commission notes that Respondent lost their ability to pay medical expenses directly (take benefit of any negotiated reductions) when the matter went to hearing before the Arbitrator with the disputed medical bills at issue, and the Commission ordering Respondent to pay the amount to Petitioner. Petitioner's counsel obtained the awarded benefits that were disputed and obtained the ability/benefit to negotiate those bills. Clearly, Petitioner's counsel is not claiming fees on medical bills that were not disputed and paid by Respondent prior to hearing. Respondent was to pay bills to Petitioner per the Commission decision and Respondent did not timely do that, to Petitioner's detriment. There was representation at the July 17, 2015 hearing on the matter that Respondent had then negotiated and paid those disputed bills directly; it is not clear if the doctor accepted payment in full satisfaction of those disputed bills.

The Commission finds that Petitioner is entitled to §19(k) penalties, with a showing that Respondent acted in an unreasonable and vexatious manner by not timely paying the medical expense portion of the award ($1,208.51 net medical expenses due) to Petitioner per the Commission order; penalties assessed under this section being 50% of the medical expense award for penalties assessed under this section, of $604.26.

Further, the Commission finds that Petitioner's attorney is entitled to §16 attorney fees of $241.70 (20% of $1,208.51) on the medical expense portion of the award not paid to Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $604.26 as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for the Petitioner legal fees in the amount of $241.70 as provided in §16 of the Act; the balance of attorneys' fees to be paid by Petitioner to his attorney.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, on the Commission decision award from August 6, 2012 through November 13, 2012.

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: MAY 15 2018

David L. Gore

DLG/jsf
5/19/17
045

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debbie Santee,

Petitioner,

vs. NO: 06 WC 14328

Around the Clock, and the Illinois State Treasurer,
as ex officio of the Injured Workers Benefit Fund,

Respondent.

18IWCC0310

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, wage rate, permanent partial disability and statute of limitations, 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 had worked for Respondent for four months as a Waitress at the time of accident. She worked part time for Respondent at night and held a part-time day job with West Side Family Restaurant.

2. On February 12, 2006 Petitioner began her shift for Respondent at 2p.m. A co-worker was scheduled to start at 4p.m. but did not show up. The establishment was packed and Petitioner was left to do the work of two people.

3. At one point, they ran out of crackers and Petitioner went to the back to retrieve more.

The floor in the back was wet after having been mopped. Someone had removed a non-stick mat to do the mopping, but had failed to put it back. While walking, Petitioner slipped and fell, landed on her right arm.

4. After being taken to the hospital and undergoing x-rays, it was revealed that Petitioner had sustained an interarticular nondisplaced fracture of the distal radius in her wrist. She was taken off work until April 3, 2006.

5. Petitioner's arm was placed in a splint. After swelling subsided, the splint was replaced with a cast for six weeks.

6. One week later, Petitioner began complaining of back pain between her shoulder blades. She treated with a chiropractor on February 20, 2006 and was referred for physical therapy.

7. By the time of trial, Petitioner no longer suffered from any wrist or back pain.

The Commission affirms the Arbitrator's rulings on the issues of medical expenses, wage rate and statute of limitations. The Commission, however, views the evidence slightly different than does the Arbitrator with regards to permanent partial disability benefits. There is no evidence of a medical opinion finding causal connection to Petitioner's back condition, and Petitioner testified at Arbitration that she no longer suffers from any back issues.

Accordingly, the Commission modifies the permanent partial disability award, vacating the 2% person as a whole award for Petitioner's back condition, but affirming the 7.5% loss of use award in relation to Petitioner's hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $212.12 per week for a period of 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 $190.91 per week for a period of 15.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 7.5% loss of use of Petitioner's right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,803.59 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.

18IWCC0310

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,200.00. 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: MAY 18 2018
O: 3/22/18
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SANTEE, DEBBIE
Employee/Petitioner

Case# **06WC014328**

AROUND THE CLOCK AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0310

On 7/24/2017, 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 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:

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

0000 AROUND THE CLOCK
15775 WILLOWBROOK RD
SOUTH BELOIT, IL 61080

5946 ASSISTANT ATTY GENERAL
HELEN LOZANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

Debbie Santee
Employee/Petitioner

Case # **06** WC **14328**

v.

18IWCC0310

Around the Clock and the Illinois State Treasurer
As Ex-Officio Custodian of the Injured Worker Benefit Fund
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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **June 20, 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 - Liability of Injured Workers' Benefit Fund

FINDINGS

On **February 12, 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 **$16,545.79**; the average weekly wage was **$318.19**.

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 **$0** under Section 8(j) of the Act.

ORDER

The Respondent shall pay the petitioner temporary total disability benefits of $ **212.12** / week for **7** weeks, from **February 13, 2006 through April 3, 2006**, as provided in Section 8(b) of the Act.

The respondent shall pay $ **3,803.59** for necessary medical services, as provided in Section 8(a) and 8.2 of the Act and consistent with the medical fee schedule.

The Respondent shall pay the Petitioner the sum of **$190.91** / week for a period of **25.375** weeks, as provided in Section 8(d)(2) and Section 8 (e) of the Act, because the injuries sustained caused **7.5% loss of use of the right hand and 2% loss of a man 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.

Arbitrator Anthony C. Erbacci

July 20, 2017
Date

JUL 24 2017

FACTS:

The parties appeared for hearing on June 20, 2017 before Arbitrator Erbacci under the Illinois Workers' Compensation Act. Petitioner was represented by counsel. Petitioner attempted to provide notice of the hearing date to Respondent, Around the Clock, by certified mail. (Px. 5). As Respondent did not have workers' compensation insurance coverage, the Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund. (Px. 4). Prior to hearing, Respondent IWBF made an oral motion to dismiss the IWBF as Petitioner added the IWBF as a party over ten years after both the alleged date of accident and date of filing. The Arbitrator denied the motion. All issues are in dispute.

Petitioner testified that on February 12, 2006, she was employed by Around the Clock as a waitress. Petitioner testified that she had worked for Around the Clock for approximately 4 months. She had been hired by Sammy, the owner, who she had known for years. When interviewed for the position, Petitioner had informed Sammy that she was working as a waitress at another restaurant, West Side Family Restaurant. Petitioner testified that she was paid approximately $3 per hour at each job, with tips on top of the hourly rate. Petitioner's wage statements from Around the Clock Restaurant, submitted at trial, noted an hourly rate of $3.90 per hour, exclusive of tips. (Px. 3). Petitioner testified that she worked approximately 25 hours a week at Around the Clock, and worked approximately 30 hours a week at West Side Family Restaurant. She worked during the day at West Side and at night at Around the Clock. Petitioner estimated earning approximately $150 per week at West Side Family Restaurant.

Petitioner testified she was one of approximately 13 employees at Around the Clock, including waitresses and cooks. They did not serve alcohol, but served food and beverages, including hot and cold food and drinks. On February 12, 2006, Petitioner was working at Around the Clock, on a busy afternoon. After running out of crackers, Petitioner went to the kitchen to get more. She testified that as she walked, she slipped and fell on the wet floor, landing on her right arm. Petitioner testified that the dishwasher had been run and someone had picked up the non-stick mat that was supposed to be on the floor. Without the mat on the floor, it was particularly slippery when wet.

Petitioner told Sammy that she had fallen and he told her to go home. However, Petitioner could not drive, so she called her sister who picked her up and took her to Beloit Memorial Hospital. (Px. 6). An x-ray showed an interarticular nondisplaced fracture of the distal radius. Her arm was splinted and she was taken off work. (Px. 6). Within a day or two, Petitioner experienced pain in her upper back and neck as well. She sought treatment with Dr. Fagerstrom, a chiropractor, on February 20, 2006. She described pain in her neck and back after a fall at work. He assessed facet syndrome and cervicalgia and provided chiropractic adjustments. (Px. 7).

Petitioner followed up with Dr. Huizenga on February 22, 2006 regarding her wrist. She was kept off work through April 3, 2006 due to the wrist fracture. (Px. 8). During that time, she continued to receive chiropractic treatment, which she testified did provide improvement of her neck and upper back symptoms. (Px. 7). Petitioner did not receive pay from Around the Clock or West Side Family Restaurant from February 12, 2006 through April 3, 2006. Petitioner lost her position at West Side as they could not hold her job while she was off work. Petitioner testified that she was also not allowed to return to work at Around the Clock, with the owner telling her to get out and not to come back after her injury.

Petitioner continued to receive chiropractic treatment for her back and neck pain through June 19, 2006. (Px. 7). She testified that she does not have ongoing pain in her wrist. She has not received treatment for the wrist since being discharged. She was able to secure similar employment after her release from care and remains employed as a waitress.

Notice of the trial date was attempted on the Respondent. (Px. 5). Petitioner offered a certificate of noncompliance from the NCCI confirming that Respondent failed to have insurance. (Px. 4). Finally, Petitioner offered exhibits 1 and 2 which were the original Application for Adjustment of Claims and the amended Application for Adjustment of Claims, adding the Injured Workers Benefit Fund is a party to the case. (Px. 1, 2). All issues were in dispute at the time of trial.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (A.), Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner and Respondent were operating under and subject to the Illinois Workers' Compensation Act on February 12, 2006. Petitioner testified that he was hired by Sammy, the owner of Around the Clock, to work as the restaurant as a waitress. Petitioner worked in South Beloit, IL and her injury occurred in Illinois. Therefore, jurisdiction is proper here in Illinois.

Petitioner testified that her job was as a waitress for Around the Clock involving serving of food and beverages to customers. The provisions of the Act apply automatically to any business or enterprise serving food to the public for consumption on the premises wherein any employee as a substantial part of the employee's work uses handcutting instruments or slicing machines or other devices for the cutting of meat or other food or wherein any employee is in the hazard of being scalded or burned by hot grease, hot water, hot foods, or other hot fluids, substances, or objects. Petitioner worked in a restaurant serving food and drinks. Therefore, the work is subject to the Illinois Worker's Compensation Act consistent with 820 ILCS 305/3(14).

The Arbitrator finds Petitioner's testimony credible and finds automatic coverage under Section 3 of the Illinois Workers Compensation Act on February 12, 2006.

In Support of the Arbitrator's Decision relating to (B.), Was there an employee-employer relationship, the Arbitrator finds and concludes as follows:

The Arbitrator finds that there was an employee-employer relationship between Petitioner and Around the Clock. Petitioner testified that she was hired by the owner to work the night shift as a waitress. Petitioner testified that she generally worked approximately 25 hours a week for Around the Clock. Petitioner submitted payroll records from Around the Clock noting the hours she worked, and her pay, from December 26, 2005 through February 5, 2006. Petitioner was paid every 2 weeks from

a business account, with taxes taken out by Around the Clock. All of this information went uncontradicted at trial. Further, the Arbitrator finds Petitioner credibly testified to his employment relationship with Respondent. Therefore, the Arbitrator finds that there was an employee-employer relationship between Petitioner and Around the Clock on February 12, 2006.

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment with Respondent on February 12, 2006. Petitioner testified that on that day, while working at Around the Clock, she slipped on a wet floor while retrieving crackers. Petitioner testified that the floor was wet and the mat had been removed, leaving the slippery, wet floor exposed. Petitioner's emergency room record indicated that she fell while at work as well, resulting in a fractured wrist. She was immediately provided treatment for the wrist injury. Petitioner's testimony regarding the accident was uncontradicted at trial and is clearly supported by the treatment records. As such, the Arbitrator finds that Petitioner suffered an injury that arose out of and in the course of her employment with Around the Clock on February 12, 2006.

In Support of the Arbitrator's Decision relating to (D.), What was the date of the accident, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the date of the accident was February 12, 2006. Petitioner was seen in the Emergency Room at Beloit Memorial Hospital shortly after the injury. The medical records support an injury date of February 12, 2006. As it conforms to proofs, the Arbitrator finds that Petitioner's accident occurred on February 12, 2006.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner provided timely notice of the accident to Respondent, Around the Clock. Petitioner testified that she informed the owner, Sammy, that she had fallen and was injured. She testified that he told her to go home but had her sister take her to the emergency room instead. No evidence was provided to contradict Petitioner's testimony. Therefore, the Arbitrator finds that timely notice was given by Petitioner to Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner's present condition of ill-being is causally related to the injury that occurred on February 12, 2006. On the date of injury, Petitioner was immediately seen at the emergency room for her wrist. She was treated with a splint and then a cast after an x-ray revealed an interarticular nondisplaced fracture of the distal radius. A week later, Petitioner was seen by Dr.

Fagerstrom, a chiropractor, due to the onset of neck and upper back pain shortly after her fall. The initial record from Dr. Fagerstrom noted that Petitioner experienced pain after falling at work. He provided chiropractic care for strains of Petitioner's neck and back over the next 4 months. (Px. 7). Petitioner's conservative treatment following her injury is consistent with the fall that she described. She testified to improvement with casting of the wrist and chiropractic care of the neck and back. Therefore, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to her February 12, 2006 injury.

In Support of the Arbitrator's Decision relating to (G.), What were Petitioner's earnings, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner earned $318.19 per week between her positions at Around the Clock and West Side Family Restaurant. Petitioner's wage records from December 26, 2005 – February 5, 2006 indicate she earned $1,009.13 over 6 weeks. This equates to $168.19 per week. Petitioner testified that he also worked at West Side Family Restaurant, making approximately the same hourly rate, but working approximately 5 hours more per week. She testified to making approximately $150 per week with tips included. $150 per week is consistent with what Petitioner earned for Respondent. As such, the Arbitrator finds that Petitioner earned a combined average weekly wage of $318.19 between the two employers.

In Support of the Arbitrator's Decision relating to (H.), What was Petitioner's age at the time of the accident, the Arbitrator finds and concludes as follows:

Petitioner testified that she was born on February 7, 1962 and was 44 years old at the time of her injury. Respondent offered no evidence to refute Petitioner's testimony. Her medical records confirm her date of birth. Therefore, the Arbitrator finds that Petitioner was 44 years old at the time of her injury on February 12, 2006.

In Support of the Arbitrator's Decision relating to (I.), What was Petitioner's marital status at the time of the accident, the Arbitrator finds and concludes as follows:

Petitioner testified that she was single, with no dependent children under the age of 18 at the time of her February 12, 2006 injury. The Respondent offered no evidence to refute Petitioner's testimony. Therefore, the Arbitrator finds that Petitioner was single and with no dependent children at the time of her February 12, 2006 injury.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary for the injuries she sustained on February 12, 2006. The Arbitrator notes that the medical

records, diagnoses, treatment carried out, and treatment recommendations are noted in the Statement of Facts. The Arbitrator finds that the Respondent failed to offer any evidence to refute the reasonableness and necessity of the medical treatment received by Petitioner for her injuries.

Therefore, the Arbitrator finds that the treatment Petitioner received at Beloit Health System, Beloit Radiology, and Chiro Care Center (Dr. Fagerstrom) were reasonable and necessary for her injury.

Based on the Arbitrator's findings that the Petitioner suffered an injury that arose out of and in the course and scope of her employment for Respondent, Around the Clock, and that the treatment Petitioner received was reasonable and necessary, the Arbitrator finds that the Respondent is liable for the treatment provided, as set forth in Petitioner's Exhibit 9. Respondent is liable for the $702.59 at Beloit Health System, $437 at Beloit Radiology, and $2,664.00 at Chiro Care Center. As such, the Respondent is liable for the unpaid medical bills, pursuant to the medical fee schedule, totaling $3,803.59.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner is owed Temporary Total Disability benefits from February 13, 2006 through April 3, 2006 for a total of 7 weeks at the TTD rate of $212.12 per week.

Petitioner was off work following her injuries and was not released regarding her fractured wrist, until April 3, 2006. Petitioner's medical records note that she was placed in a splint and taken off work on February 12, 2006 when seen at Beloit Memorial Hospital. She was continued off work by Dr. Huizenga at Beloit Clinic on February 22, 2006. Dr. Huizenga continued Petitioner off work on March 3, 2006 and March 20, 2006. On April 3, 2006, he released her to return to full duty work regarding her wrist. While Petitioner was not able to return to work for Around the Clock or West Side Family Restaurant, she was no longer restricted and had reached maximum medical improvement as of April 3, 2006. As such, the Arbitrator finds that Petitioner is entitled to Temporary Total Disability benefits from February 13, 2006 through April 3, 2006.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

Having found that Petitioner's work injury of February 12, 2006 to have occurred in the course of her employment for Respondent, Around the Clock, and to be the cause of Petitioner's current condition of ill-being, the Arbitrator finds that Petitioner sustained a permanent loss of use the right wrist and of the person as a whole. Petitioner testified to a lack of need for ongoing treatment since her release from care for her wrist in April of 2006 and her neck and back in June of 2006. She has been able to return to similar type of work. However, Petitioner did lose both her job for Respondent and for West Side Family Restaurant as a result of her injury. As such, The Arbitrator orders the Respondent to pay Petitioner 25.375 weeks of permanent partial disability benefits pursuant to

Sections 8(d)(2) and 8(e) of the Act at the Permanent Partial Disability rate of $190.91, finding that her injuries resulted in 7.5% loss of use of the right wrist and 2% loss of a man as a whole.

In Support of the Arbitrator's Decision relating to (O.), Is Respondent IWBF liable, the Arbitrator finds and concludes as follows:

Petitioner provided proof of non-insurance for Respondent-employer Around the Clock provided by the Insurance Compliance Division. PX. 4. Petitioner also provided notice to the employer sent via certified mail. PX. 5. The Arbitrator finds that given Respondent-employer Around the Clock's lack of insurance Respondent IWBF is liable. The Arbitrator also finds that notice to Respondent IWBF is proper.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brandon Mack,
Petitioner,

vs. No. 10 WC 34359

18IWCC0311

Lagasse Sweet,
Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B) AND §8(A)

Timely Petitions for Review having been filed by both Respondent and Petitioner herein, and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary disability, prospective medical care, and the two-doctor chain of referral, 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 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).*

By way of background, Petitioner, a 19-year-old forklift operator, testified at a prior §19(b) hearing in this matter on November 15, 2010 that while reaching for a box at work on August 23, 2010, he felt a sharp pain in his low back. He declined his employer's offer to see a doctor and continued working. Petitioner's first treatment was not until 4 days later, when he went to Concentra. There, he was diagnosed with a lumbar strain and given work restrictions. Following the November 15, 2010 hearing, the Arbitrator found Petitioner's condition of ill-being causally related to his work accident, and awarded him 10-6/7 weeks of temporary total disability benefits, medical expenses of $10,817.02 and prospective medical care. On December 23, 2011, the Commission affirmed and adopted that Arbitrator's decision.

This current review follows Petitioner's second §19(b) hearing, which commenced on December 15, 2015 and concluded on January 19, 2016. At that hearing, Petitioner testified his back pain had persisted since his first hearing. He testified he received treatment from: Elmhurst Clinic, Advanced Pain Center, Suburban Orthopedics, George Chiropractic, Westgate Orthopaedics and Dr. Min Kim. On February 3, 2012, he began treatment with Dr. Forrest Robinson, whom he still sees. At his last visit to Dr. Robinson, Petitioner complained of shooting and stabbing pain in his lower back and legs with tingling.

Petitioner's treatment since his work accident has been conservative, consisting of physical therapy, pain medications and epidural steroid injections. None of his medical providers believed surgery was required. Petitioner underwent 4 lumbar MRI's, all of which showed, at most, small bulges but no herniations. His second MRI on April 27, 2011 was read as normal. His third, on February 20, 2012, suggested a bulge at L4-5 might be contacting nerve roots, although his treaters considered that MRI to be essentially unremarkable and fairly benign.

On cross-examination, Petitioner denied the following: that Dr. Freedberg diagnosed him with only a strain; that Dr. Boone Bracket ordered an MRI; that Dr. Robinson was his choice of physician; that he saw Dr. Onibokun a second time to review the MRI he ordered, and that he was diagnosed with a lumbar sprain as a result of his July 23, 2014 auto accident. Petitioner testified he asked for and received work restrictions from Dr. Robinson, although Dr. Robinson denied that at his deposition.

Lisa Johnson, an HR Manager at Respondent, testified that since July 2014, she called Petitioner on a monthly basis to see if he had been released to work. She testified that Respondent was able to accommodate some work restrictions, and that if Petitioner had brought in a note with work restrictions, Respondent would have tried to accommodate them.

Dr. Forrest Robinson testified at a deposition that he first saw Petitioner on February 3, 2012, a year and a half after his accident. Then, Petitioner complained of severe low back pain radiating to his buttocks and thighs. Dr. Robinson diagnosed of Petitioner with disorder of the back, a bulging lumbar disk and "source syndrome." Dr. Robinson opined: Petitioner's low back pain and radiation were a direct result of repetitive lifting at work on August 23, 2010; his bulging disks were pressing on a nerve; his lower extremity EMG supported a compression neuropathy, and Petitioner was unable to hold a job.

Dr. Robinson admitted the following: he never reviewed Petitioner's 2011 MRI or records from Dr. Brackett, Good Samaritan Hospital or Suburban Orthopaedics; he was not aware that Suburban Orthopaedics had diagnosed Petitioner with only a back strain, and his basis for keeping Petitioner off work while under his care was Petitioner's subjective report pain with no improvement. Dr. Robinson admitted Petitioner never told Robinson about his February 22, 2011 motor vehicle accident. Dr. Robinson admitted Petitioner's MRI's did not show enough to support the magnitude of his pain, and that his neck symptoms following his July 23, 2014 motor vehicle accident were related to that motor vehicle accident. Dr. Robinson agreed it would be "very difficult" to determine what portion of Petitioner's thoracic and lumbar pain was attributable to his MVA and to his work accident.

Dr. Robinson acknowledged that most properly treated back strains resolve in less than 3-6 months. Petitioner's objective symptoms were primarily back spasms and one positive SLR test. Dr. Robinson did not know what an "invalid" FCE was, being only vaguely familiar with them.

Dr. Sean Salehi, Respondent's board-certified, Section 12 neurosurgeon, testified he examined Petitioner and reviewed his medical records on April 8, 2011. Petitioner denied prior accidents including motor vehicle accidents. At Dr. Salehi's exam, Petitioner complained of 9/10 to 10/10 low back pain and shooting bilateral leg pain. Dr. Salehi believed Petitioner was then able to work at light duty.

After Dr. Salehi reviewed additional records and MRI films, he provided the following opinions: Petitioner's diagnosis was low back pain; his MRI showed no evidence of disc herniation or degeneration, and the synovial cyst was an incidental finding not causing any neural compression. Petitioner needed only 10 work-conditioning sessions to reach MMI and be able to return to work without restrictions. Dr. Salahi found Petitioner's April 27, 2011 MRI to be a normal study, and that Petitioner required no aggressive care. Dr. Salahi opined the epidural steroid injections Petitioner received were not medically necessary, because Petitioner had no evidence of neural compression, herniated disc, loss of reflexes, or true radiculopathy.

Medical records in evidence included those from Concentra Medical Center, which, on August 27, 2010, diagnosed Petitioner with a lumbar strain, and on August 31, 2010, documented no new complaints or bilateral lower extremity numbness and radiation. A September 2, 2010 emergency department report from Edward Hospital listed Petitioner's diagnosis on that date as, "acute lumbosacral strain." Dr. Howard Freedberg's diagnosis on that same day was thoraco-lumbar sprain/strain and cervical myalgia/sprain. On November 3, 2010, Dr. Freedberg reported that no surgery was indicated.

Chiropractor Calvin George's records included a Patient Application Survey dated December 28, 2010, which indicated Petitioner was a, "Walk-in" patient who complained of low back pain. After 3 months of treatment, Dr. George diagnosed Petitioner with "intervertebral disc syndrome," and he referred him to Dr. Boone Brackett. Dr. Brackett ordered a lumbar MRI, which showed no abnormal disc protrusion, and was interpreted as "normal." On May 3, 2011, Dr. Brackett documented that Petitioner denied any leg radiation. On May 12, 2011, Dr. Brackett reported the "little bulges" on Petitioner's MRI did not look like much, and he told Petitioner he should go back to work.

Petitioner was seen at Good Samaritan Hospital on February 23, 2011, following a motor vehicle accident the day before. Then, Petitioner reported low back pain radiating down both legs to his ankles intermittently for the past 8 months, or approximately two months prior to his August 23, 2010 work accident. A subsequent record of Good Samaritan's emergency room dated August 16, 2012 documented Petitioner's history of chronic low back pain since a motor vehicle collision two years earlier.

Dr. Robinson's records show he first saw Petitioner on February 3, 2012, for complaints of middle and lower back pain which Petitioner attributed to his work accident. Dr. Robinson referred Petitioner to neurosurgeon Dr. Adebukola Onibokun, and to physiatrist, Dr. Min Kyung Kim. Petitioner first saw Dr. Onibokun on August 27, 2012, at which time that doctor reported

Petitioner's lumbar MRI was unremarkable. Dr. Onibokun saw Petitioner again on April 3, 2013, noting Petitioner's repeat MRI was also unremarkable, and showed no significant lumbar disc herniations, lumbar subluxation or lumbar nerve root compression.

Petitioner first saw Dr. Kim on October 24, 2012. Dr. Kim recommended Petitioner stop taking Norco, and she refused to refill that medication for Petitioner. On April 17, 2013, Dr. Kim reported Petitioner did not wish to undergo recommended work conditioning for fear of straining his back. He also told Dr. Kim he felt he could not perform a sedentary job for 8 hours per day. Dr. Kim suggested an easier work conditioning program, consisting of only one hour a day at first, but Petitioner refused that recommendation. On May 18, 2015, Dr. Kim found no physical limitation which prevented Petitioner from working, and recommended he find a job which allows him to sit and move around as needed.

On August 20, 2014, Dr. Robinson reported Petitioner had new back pain which started 1-4 weeks earlier – following a motor vehicle accident. On June 26, 2014, Dr. Robinson authored a "To whom it may concern" letter in which he opined that all of Petitioner's low back pain and radiation were directly resulting from his August 2010 work accident. Dr. Robinson believed Petitioner had a compression neuropathy and was not able to hold a job.

Conclusions:

The issue of causal connection of Petitioner's cervical, thoracic and lumbar sprains and strains, and cervical myalgia,as it relates to his condition . This Commission finds, however, that Petitioner attained MMI for his injuries on May 12, 2011, when Dr. Brackett found him able to work. In so concluding, the Commission finds Dr. Brackett's opinions more credible and persuasive than Dr. Robinson's. The Commission further notes Dr. Brackett's opinions are consistent with and supported by Dr. Salahi's, as well as by Petitioner's four benign lumbar MRI's and the invalid FCE.

The Commission finds Dr. Robinson's opinions less persuasive, because they were based largely upon Petitioner's subjective complaints, many of which were not substantiated by his medical records. Further, Dr. Robinson referred Petitioner to two specialists, Dr. Onibokun and Dr. Kim; yet did not defer to those experts' recommendations (*e.g.*, for Petitioner to stop taking Norco, and to return to at least part-time, light duty employment). Instead, Dr. Robinson continued to prescribe Norco and authorize Petitioner off work.

The Commission finds Petitioner's credibility questionable. Numerous conflicts exist between his testimony and medical records. Petitioner told Dr. Salehi on April 8, 2011 he had never been involved in motor vehicle accidents, when in fact he had been in one just two months earlier. He testified he told his treaters at Edward Hospital that he had shooting pains down both legs, but their September 2, 2010 record states, "The patient has no radicular findings." Petitioner told treaters at Good Samaritan Hospital his low back pain radiating to his ankles began months before his work accident. Petitioner testified he gave his employer a note clearly stating he could work with restrictions; Lisa Johnson testified that he never did.

Other evidence reflects negatively upon Petitioner's credibility. The ATI physical therapist reported Petitioner's FCE was an invalid representation of his physical capabilities, based on inconsistencies with his exercises, selectivity of pain reports and pain behaviors. The ATI therapist further believed Petitioner's FCE results represented, "a manipulated effort by the client." Finally, two doctors, Dr. Salahi and Dr. Yousuf Sayeed, each found positive Waddell's during their examinations of Petitioner.

A pattern appears, suggesting Petitioner's motivation to return to work was lacking. He told his doctor at Concentra, on August 31, 2010, he wanted to be off work. That request was denied. Dr. Kim recommended Petitioner undergo work conditioning and go back to part-time work. He did neither. Treating physician Boone Brackett found Petitioner able to work, and reported, "I think he can go back to work. He says he can't." Petitioner did not return to work following Dr. Brackett's recommendation.

The Commission modifies the Arbitrator's award of temporary total disability benefits awarded since Petitioner's initial §19(b) hearing, to 25-3/7 weeks, for the period of November 16, 2010 through May 12, 2011. The Commission denies all medical expenses Petitioner incurred after that date as not being causally related to his work accident.

Finally, though now moot, the Commission affirms and adopts the Arbitrator's finding that Dr. Robinson and the Elmhurst Clinic were outside of Petitioner's two-doctor chain of referral. The Arbitrator found Petitioner's first choice physician to be Suburban Orthopedics (Dr. Freedberg), and his second choice, chiropractor Calvin George. The Commission affirms those findings, and finds unpersuasive Petitioner's claim that Dr. George referred him to Dr. Robinson, as there is no documentary evidence corroborating Petitioner's testimony. Dr. George kept copies of the referral letters he wrote to Drs. Montella and Dr. Brackett, but had none showing he referred Petitioner to Dr. Robinson. The Commission finds Dr. Robinson was Petitioner's third choice. This issue is moot, however, because the treatment Petitioner received from Dr. Robinson and Elmhurst Clinic was all undertaken after his May 12, 2011 MMI date.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed October 4, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $294.71 per week, commencing November 16, 2010 through May 12, 2011, totaling 25-3/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act, since the November 15, 2010 arbitration hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified, and Respondent shall pay only the reasonable and necessary medical expenses incurred for treatment of Petitioner's causally related cervical, thoracic and lumbar sprains and strains through his date of MMI on May 12, 2011, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that prospective medical care is denied.

18IWCC0311

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

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

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

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: MAY 21 2018

o-03/21/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

MACK, BRANDON
Employee/Petitioner

Case# **10WC034359**

LAGASSE SWEET
Employer/Respondent

18IWCC0311

On 8/26/2016, 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 0.45% 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:

0607 CHARLES LEVY & ASSOC LTD
3525 W PETERSON AVE
SUITE 206
CHICAGO, IL 60659

0000 HOLECEK & ASSOCIATES
MONICA J DEMBNY
215 SHUMAN BLVD SUITE 206
NAPERVILLE, IL 60563

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)

BRANDON MACK
Employee/Petitioner

v.

LAGASSE SWEET
Employer/Respondent

Case # 10 WC 34359

Consolidated cases: _____

18IWCC0311

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton**, on **December 15, 2015 and in the city of Chicago on January 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **08/23/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,798.71**; the average weekly wage was **$442.07**.

On the date of accident, Petitioner was **19** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$35,575.78** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$35,575.78**.

Respondent is entitled to a credit of **$31,783.24** for medical bills under Section 8(j) of the Act.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner the temporary total disability benefits of **$294.71** per week for the **10-6/7** week period awarded by Arbitrator Andros at the November 15, 2010 trial as well as temporary total disability benefits of **$294.71** per week for **130-4/7** weeks for the periods from **November 16, 2010** through **October 25, 2011** and from **June 26, 2014** through **January 19, 2016**, in accordance Section 8(b) of the Act.

Medical Benefits

The Arbitrator finds that Respondent shall pay Petitioner an amount equal to the total of the outstanding bills for all reasonable, necessary and related medical care rendered to him by Suburban Orthopaedics (Px. 1), Advanced Pain Center (Px. 2), Westgate Orthopedics (Px. 3), and George Chiropractic, from November 16, 2010 through January 19, 2016, in accordance with Section 8(a) and subject to Section 8.2 of the Act. The Arbitrator denies the bills of Dr. Forest Robinson and Elmhurst Clinic because they are outside the two-doctor chains of referral.

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.

Brian T. Cronin

BRIAN T. CRONIN

August 26, 2016

AUG 26 2016

BRANDON MACK v. LaGASSE SWEET
10 WC 34359

ARBITRATION DECISION

FINDINGS OF FACT

A prior 19(b) hearing in this case was conducted on November 15, 2010, and the Decision of Arbitrator Andros was affirmed and adopted by the Commission on December 23, 2011. (Jt. Ex. 1). The Arbitrator found that on August 23, 2010, the Petitioner, Brandon Mack, was 19 years old and working as an order picker for the Respondent, LaGasse Sweet. (Jt. Ex. 1). As part of his job, he was required to raise himself up in a cherry picker and reach up and out to pick up boxes and place them onto pallets. (Jt. Ex. 1). On August 23, 2010, he was reaching towards the back of a row to lift boxes of toilet paper when he felt pain in his lower back. (Jt. Ex. 1). The Arbitrator found that timely notice of this accident was given to the Respondent, that the accident arose out of and in the course of employment, the Petitioner's condition of ill-being was causally related to the accident, and that the Petitioner's average weekly wage was $442.07. (Jt. Ex. 1).

Subsequent to the hearing, the Petitioner received medical treatment from Suburban Orthopaedics (Px. 1), Advanced Pain Center (Px. 2), Westgate Orthopedics (Px. 3), George Chiropractic (Px. 4), Advocate Good Samaritan Hospital (Px. 5), Elmhurst Clinic (Px. 6), and Gottlieb Memorial Hospital (Rx. 5) The Petitioner was also examined by Dr. Salehi pursuant to Section 12 of the Act. (Rx. Group 2)

A 19(b) hearing was commenced on December 15, 2015 and concluded on January 19, 2016. The Petitioner's testimony was heard as well as the testimony of Lisa Johnson, the Respondent's Human Resources Manager.

CONCLUSIONS OF LAW

F. In support of the Arbitrator's Decision as to whether the Petitioner's current condition of ill being is causally related to the injury, the Arbitrator makes the following findings:

The Arbitrator has considered the Petitioner's testimony, the Decision and Opinion on Review (Jt. Ex. 1), medical records from Suburban Orthopaedics (Px. 1), Advanced Pain Center (Px. 2), Westgate Orthopedics (Px. 3), George Chiropractic (Px. 4), Advocate Good Samaritan Hospital (Px. 5), Elmhurst Clinic (Px. 6), Westfield Insurance (Rx. 4), Gottlieb Memorial (Rx. 5) and Delphi Memorial (Rx. 6), as well as the deposition testimony of Dr. Robinson (Px. 6) and Dr. Salehi (Rx. Group 2), the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the injuries he sustained in his work accident of August 23, 2010.

The Commission has previously determined that the Petitioner's condition of ill-being as of November 15, 2010 was causally related to his work accident of August 23, 2010. (Jt. Ex. 1) Following the previous 19(b) hearing on November 15, 2010, the Petitioner continued to receive medical treatment from Dr. Freedberg at Suburban Orthopedics. (Px. 1) His next appointment with Dr. Freedberg after the hearing was on November 29, 2010 at which time he continued to have bad spasms and swelling in his lower back. (Px. 1) At that time, the Petitioner's stated diagnosis was sprain/strain of the spine, mainly thoracic and lumbar, with cervical myalgia/sprain with developed radiculopathy, however, a lumbar MRI taken on October 13, 2010 showed minimal annular bulges at the L3-4 through L5-S1 levels. (Px. 1) The doctor stated at this appointment that he was medically unable to work. (Px. 1) The Petitioner returned to Dr. Freedberg on December 6, 2010 and January 5, 2011 with the same complaints. (Px. 1) He had received an injection which did not help and continued to have lower back spasms, swelling and shooting and burning pain down both legs. (Px. 1) Dr. Freedberg kept the Petitioner off work. In his January 5, 2011 chart note, Dr. Freedberg wrote: "... he is going to try Chiropractic Therapy as recommended by a friend and we will hold PT at this time." (Px.1)

Petitioner's Exhibit #4 indicates that the Petitioner began treating at George Chiropractic on January 3, 2011. At that time he noted that he was recovering from an acute lumbar disc injury and he was instructed to remain off work until "unable to say at this time". (Px. 4) The Petitioner received chiropractic care from George Chiropractic from January 3, 2011 through April 25, 2011. (Px. 4)

The Petitioner testified that on February 22, 2011, he was involved in a motor vehicle accident and he was seen in the emergency room of Advocate Good Samaritan Hospital on February 23, 2011. (Px. 5) The emergency room records indicate that he was jerked forward and backwards and suffered an acute cervical and thoracic strain, and also an acute exacerbation of his chronic low back pain. (Px. 5)

George Chiropractic referred the Petitioner to Dr. Brackett on the basis that his office was closer to the Petitioner's home. (Px. 4)

The Petitioner first saw Dr. Brackett on April 26, 2011 at which time he still had consistent complaints of pain in his back and numbness in his legs. (Px. 3) Dr. Brackett found that the Petitioner had a straightened lumbar back with some paraspinal spasm, 50% limited range of motion in all parameters with some paraspinous spasm and he could not do toe gait on the left side because of pain. (Px. 3) Dr. Brackett ordered another lumbar MRI which was performed on April 27, 2011. (Px. 3) The Petitioner's last appointment with Dr. Brackett was on May 12, 2011 at which time it was documented that he had so much pain he was unable to walk and that the MRI showed "some little bulges here that don't look like much". (Px. 3) Despite the Petitioner's continued complaints and MRI findings, Dr. Brackett recommended that the Petitioner find another, smarter doctor to find out what was wrong with him. (Px. 3)

At the request of the Respondent, the Petitioner was examined by Dr. Salehi pursuant to Section 12 of the Act on April 8, 2011. (Rx. 2) Dr. Salehi opined that the Petitioner's work accident

resulted in either a lumbar strain or annular tear of one of his lumbar discs, but that he was not a surgical candidate. (Rx. 2)

On October 25, 2011, after reviewing the October 13, 2010 lumbar MRI, Dr. Salehi wrote that he had no good explanation for the Petitioner's radicular symptoms or any ongoing lower back pain saw no significant structural pathology. He opined that an FCE would not be needed. He recommended that the Petitioner undergo 10 sessions of work conditioning (at which time he would be at MMI) followed by a return to his pre-injury level of work. (Rx. 2, Dep. Ex. 4)

On February 3, 2012, the Petitioner began treating with Dr. Forrest Robinson at Elmhurst Clinic. Dr. Robinson documented that the Petitioner was experiencing persistent, severe pain in his mid to lower back, radiating to his left and right thighs and buttocks. (Px. 6) The Petitioner described his pain to Dr. Robinson as burning, discomforting, sharp and shooting. (Px. 6) Dr. Robinson attributed the Petitioner's condition to his work accident of August 23, 2010, prescribed Valium and Vicoprofen and ordered a lumbar MRI. (Px. 6) The MRI was performed on February 20, 2012 and showed disc bulges at L4-5 and L5-S1. (Px. 6) The MRI report states that the bulge at L4-5 may contact the exiting L4 nerve roots in the lateral recesses and the bulge at L5-S1 results in mild-to-moderate neural frontal stenosis. (Px. 6) Dr. Robinson referred the Petitioner to Dr. Kim Min for pain management and the Petitioner received epidural steroid injections to his low back on April 10, 2012, October 8, 2012 and January 11, 2013 which did not relieve his pain. (Px. 2, Px. 6). The Petitioner underwent an FCE on June 20, 2012 which was determined to be invalid. (Px. 2) Another MRI was performed on March 6, 2013 which again showed multi-level bulging discs, and an EMG showed bilateral radiculopathy. (Px. 6)

On June 9, 2014, the Petitioner had a lumbar MRI which showed mild posterior bulging at L3-4, L4-5 slightly impinging on the inferior aspects of the foramina on the right at L3-4 and more

to the left at L4-5. (Px. 6) On that same date he had also had a myelogram of the lumbar spine which showed mild disc bulges at L2-3 and L3-4.

The Petitioner testified that on July 23, 2014, he was involved in a motor vehicle accident and was seen in the emergency room of Gottlieb Memorial Hospital. The emergency room notes stated that he had a history of asthma and low back pain and presented with headache, neck, back and hand pain. (Rx. 5) He returned to Dr. Robinson and on September 3, 2014, Dr. Robinson documented that the Petitioner's chronic pain in his back and radicular pattern of pain were temporarily heightened by his recent car accident, however, the work injury was still incapacitating in itself. (Px. 6) The Petitioner has continued to see Dr. Robinson one two times per month for his chronic pack pain. (Px. 6)

Throughout the nearly four years that the Petitioner has been under the care of Dr. Robinson, his complaints have remained consistent and attributable to his work accident of August 23, 2010. The Arbitrator finds the testimony of the Petitioner and the testimony and records of Dr. Robinson to be credible.

Dr. Robinson testified, in pertinent part, to the following: "Mr. Mack has suffered now for almost four years with low back pain with a radicular nature to both lower extremities which is a direct result of the injury he sustained at work while lifting heavy boxes repetitively on 8-23-2010." (Px. 6, p. 16)

The Arbitrator finds that the motor vehicle accidents of February 22, 2011 and July 23, 2014 caused temporary aggravations of the Petitioner's low back condition; neither event broke the chain of causation.

Every 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 intervening accident that breaks the chain of causation between the work-related injury and the ensuing disability or

injury. National Freight Indus. v. Illinois Workers' Comp. Comm'n, 993 N.E.2d 473, 373 Ill. Dec. 167 (5th Dist. 2013) citing Vogel v. Indus. Comm'n, 354 Ill. App.3d 17 786 (2005) and Teska v. Indus. Comm'n, 640 N.E.2d 1, 203 Ill. Dec. 574 (1994).

Therefore, the Arbitrator finds that the Petitioner's current condition of ill-being of his low back is causally related to his work accident of August 23, 2010.

J. **In support of the Arbitrator's Decision as to whether the medical services that were provided to the Petitioner reasonable and necessary and whether the Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following findings:**

The Petitioner testified as to the medical services he has received as a result of his work accident of August 23, 2010. The Arbitrator finds that the medical services that were provided to the Petitioner by Suburban Orthopaedics (Px. 1), Advanced Pain Center (Px. 2), Westgate Orthopedics (Px. 3), George Chiropractic (Px. 4) were reasonable and necessary.

The Arbitrator further finds that the Respondent has not paid all appropriate charges for all reasonable and necessary medical services. The Petitioner's group insurance carrier, Cigna, paid a total of $31,783.24 (Px. 8) The treatment that the Petitioner received from Elmhurst Memorial Healthcare was paid in part by Medicaid-Illinicare.

The Arbitrator finds that Petitioner exceeded his choice of providers under Section 8(a) of the Illinois Workers' Compensation Act. Petitioner initially chose Suburban Orthopedics. Per the records from Suburban Orthopedics, Petitioner chose to treat with a chiropractor as "recommended by a friend." (Px.1) Petitioner chose to treat with Dr. George, a chiropractor. Dr. George referred Petitioner to Dr. Brackett, who did not recommend any treatment. Petitioner then chose to treat with Dr. Robinson. Dr. Robinson did not testify that Petitioner was referred to him by a doctor or chiropractor within Petitioner's two chains. (Px. 6) There is no indication in Dr. Robinson's records that anyone referred the Petitioner to him. Therefore, the Arbitrator finds that Petitioner's first choice of medical providers was Suburban

Orthopedics, and his second choice was Dr. George.

The Arbitrator finds that Respondent shall pay Petitioner an amount equal to the total of the outstanding bills for all reasonable, necessary and related medical care rendered to him by Suburban Orthopaedics (Px. 1), Advanced Pain Center (Px. 2), Westgate Orthopedics (Px. 3), and George Chiropractic, from November 16, 2010 through January 19, 2016, in accordance with Section 8(a) and subject to Section 8.2 of the Act. The Arbitrator denies the bills of Dr. Forest Robinson and Elmhurst Clinic because they are outside the two-doctor chains of referral.

K. In support of the Arbitrator's Decision as to whether the Petitioner is entitled to any prospective medical care, the Arbitrator makes the following findings:

Dr. Robinson has prescribed prospective medical care for the Petitioner.

However, Dr. Robinson is outside of the two-doctor chains of referral. Therefore, the Petitioner's claim for prospective medical care as provided by Dr. Robinson or any treater or medical provider to whom he refers the Petitioner is denied.

L. In support of the Arbitrator's decision regarding temporary total disability, the Arbitrator makes the following findings:

After considering the prior findings of Arbitrator Andros, the testimony at hearing and deposition and the medical evidence, the Arbitrator finds that the Petitioner is temporarily and totally disabled commencing August 24, 2010, August 27, 2010, August 31, 2010 through November 15, 2010 (except September 1, 2010) and November 16, 2010 through October 25, 2011, and June 26, 2014 through January 19, 2016.

The Respondent is entitled to a credit for TTD paid from August 24, 2010 through September 1, 2012, in the amount of $35,575.78. (Rx. 9)

The Petitioner's entitlement to TTD commencing August 24, 2010, August 27, 2010 and August 31, 2010 through November 15, 2010 (except September 1, 2010) has been previously decided by Arbitrator Andros and adopted by the Commission and is therefore *res judicata*. (Jt. Ex. 1)

Following the previous 19(b) hearing held on November 15, 2010, the Petitioner continued to receive medical treatment from Dr. Freedberg at Suburban Orthopedics until approximately January 5, 2011. (Px. 1) During this time, Dr. Freedberg continuously opined that the Petitioner was medically unable to work. (Px. 1) The Petitioner received chiropractic care from George Chiropractic from January 3, 2011 through April 25, 2011, during which time Dr. George did not release the Petitioner to perform any type of work. (Px. 4) At the request of the Respondent, the Petitioner was examined by Dr. Salehi pursuant to Section 12 of the Act on April 8, 2011. (Rx. 2) Dr. Salehi opined that at that time, the Petitioner was not able to return to his pre-injury level of employment and was only capable of working light duty. (Rx. 2)

The Petitioner was then seen by Dr. Brackett of Westgate Orthopedics who opined that he was able to return to work on May 13, 2011, despite the Petitioner's continued complaints of pain and MRI findings that showed disc bulges. (Px. 3)

After Dr. Salehi reviewed the Petitioner's MRI report, in a report dated October 25, 2011, he wrote that the Petitioner should undergo 10 sessions of work conditioning followed by a return to his pre-injury level of work. (Rx. 2, Dep. Ex. 4) The Petitioner testified that he has not undergone any type of work conditioning program.

The Petitioner began treating with Dr. Forrest Robinson on February 3, 2012. On October 24, 2012, the Petitioner told Dr. Min that Dr. Robinson had taken him off work and asks Dr. Min if Min could write a letter. On November 19, 2012, the Petitioner told Dr. Min that he was sent back to light-duty work for 4-6 hours a day and wondered if that would conflict with his therapy sessions.

On April 19, 2013, the Elmhurst Clinic chart notes indicate: "I reservedly consent to a trial return to work under the suggested restrictions by Dr. M. Kim. Will write a letter to substantiate." There is no evidence that the Petitioner returned to work for the Respondent or anyone else at that time. (Px. 6, Dep. Ex 2)

It is not until June 26, 2014, that Dr. Robinson opines that the Petitioner is unable to return to work. Up until that date, there are no off-work notes or off-work prescriptions by Dr. Robinson or Dr. Min. (Px. 6, Dep. Ex 2)

The Respondent stopped paying TTD to the Petitioner on September 1, 2012. (Rx. 9) At hearing, the Respondent produced an ADA "Interactive Process" Contact Log, over the Petitioner's objection, that purportedly documented the company's contact with the Petitioner concerning his inability to return to work. (Rx. 1) The Petitioner testified that at Lisa Johnson's request, he asked Dr. Robinson to allow him to return to work with restrictions. He testified that the doctor complied with his request and gave him a letter with restrictions, receipt of which is documented in the ADA log, however, neither Lisa Johnson at hearing nor Dr. Robinson at deposition were able to locate this letter. (Rx. 1, Px. 6) Nonetheless, the Respondent was unable to accommodate the Petitioner's restrictions, and the Petitioner remains unable to return to his job.

Therefore, the Arbitrator finds that that the Petitioner was temporarily and totally disabled commencing August 24, 2010, August 27, 2010, August 31, 2010 through November 15, 2010 (except September 1, 2010) and November 16, 2010 through October 25, 2011 and June 26, 2014 through January 19, 2016.

In support of the Arbitrator's decision regarding nature and extent, the Arbitrator makes the following findings:

The Petitioner testified that he continues to have burning, aching pain in his lower back, and shooting, stabbing pain in his legs as a result of this accident. When his testimony was taken on

December 7, 2015, Dr. Robinson testified that the Petitioner is in need of prospective medical care and ordered an MRI of Petitioner's lumbar spine. Dr. Robinson has not found the Petitioner to be at MMI. Therefore, a finding as to the nature and extent of the Petitioner's accidental injury would be premature and the Arbitrator declines to make such finding.

Brian Cronin
Arbitrator

8-26-2016

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

Mathew Rys,
Petitioner,

vs.

NO: 05 WC 18103

Chicago Transit Authority,
Respondent.

18IWCC0312

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 permanent disability as well as Petitioner's Motion for Resolution of Housing Issue, 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.

I. Permanent Disability

The Arbitrator awarded statutory permanent total disability under Section 8(e)18 for the loss of use of both legs, as well as 100% loss of use of the right hand, 100% loss of use of the left hand, and 50% loss of use of the left foot. The propriety of awarding both statutory permanent total disability and loss of scheduled members was established by the Illinois Supreme Court in *Beelman Trucking v. Illinois Workers' Compensation Commission*, 233 Ill. 2d 364, 909 N.E.2d 818 (2009). As such, there is no question Petitioner can recover beyond the Section 8(e)18 benefits. Nonetheless, we view the permanent disability evidence differently.

Upper Extremities

The Arbitrator found Petitioner sustained 100% loss of use of the right hand and 100% loss of use the left hand. The assignment of Petitioner's upper extremities disabilities as losses of the hands is seemingly predicated on Dr. Chen's narrative report, wherein the doctor documented Petitioner retained limited upper extremity function, with the ability to raise both arms, and opined

the injury caused "permanent and complete loss of use of his legs, and complete loss of use and function of both hands." PX13. The Commission observes Dr. Chen's report was written in January of 2011. By the time of Petitioner's deposition and the 2017 arbitration hearing, the functional deficits in Petitioner's upper extremities had significantly worsened. Petitioner's testimony establishes his disability extends to his entire right arm: Petitioner has no real functional use of his right arm and can only perform minimal movements to reposition it on the wheelchair armrest. PX15, p. 37. Likewise, Petitioner testified to having only limited use of his left arm: he can hold a toothbrush and brush his teeth (so long as the nurse holds his forearm), he can raise his arm to approximately shoulder level, and he can use his left hand to operate his wheelchair and hold his cell phone. PX15, p. 36-37. Under these circumstances, we believe the proper measure of Petitioner's upper extremities disabilities are losses of use of the arms.

The Commission finds Petitioner sustained the complete loss of use of the right arm, which will be discussed further below, and 95% loss of use of the left arm under Section 8(e)10. The Commission vacates the awards of 100% loss of the right and left hand under Section 8(e)9.

Statutory Permanent Disability

As stated above, statutory permanent total disability benefits were awarded based on Petitioner's permanent and complete loss of use of both legs. The evidence clearly demonstrates, however, Petitioner sustained a left Achilles injury in 1997 which subsequently settled for 15% loss of use of the left leg under Section 8(e)12. PX15, p. 42. The Commission finds basing statutory permanent total disability on the complete loss of use of the left leg improperly nullifies Respondent's Section 8(e)17 credit for the prior left leg injury.

Section 8(e)17 provides, "In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the...permanent partial loss of use of [hand, arm, thumb or fingers, leg, foot or any toes] or the partial loss of sight of an eye, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury." *820 ILCS 305/8(e)17*. In *Caterpillar Tractor Co. v. Industrial Commission*, 397 Ill. 474, 482, 74 N.E.2d 787 (1947), the Illinois Supreme Court explained the historical background of the subsection was to address "certain inequities in the Workmen's Compensation Act brought to light in *Chicago Bridge and Iron Co. v. Industrial Com.*...," and the general intention of the legislature in enacting the provision "was to limit an employer to liability to pay only for the loss resulting directly from the last injury...." As such, Section 8(e)17 requires the Commission to take the prior loss into consideration and deduct it from any subsequent award; this allows the Commission "to achieve the remedial purpose of the statute while achieving a result that is just and equitable." *Keil v. Industrial Commission*, 331 Ill. App. 3d 478, 481, 771 N.E.2d 626 (2002).

The award as written runs afoul of our mandate and undermines the legislature's intent in enacting the credit provision. Therefore, we modify the Section 8(e)18 award to find statutory permanent total disability based upon Petitioner's permanent and complete loss of use of the right leg and the right arm. We further find Petitioner sustained the 100% loss of use of the left leg under Section 8(e)12. Respondent is entitled to credit for the prior loss under Section 8(e)17.

18IWCC0312

Left Foot

The Arbitrator awarded a 50% loss of use of the left foot. Having already awarded Petitioner 100% loss of use of the left leg, the Commission finds an award for loss of the left foot is duplicative. The Commission vacates the award of 50% loss of use of the left foot.

To summarize, the Commission finds Petitioner is permanently disabled to the following extent:

- statutory permanent total disability under Section 8(e)18 for the permanent and complete loss of use of the right leg and the right arm;

- 100% loss of use of the left leg under Section 8(e)12, subject to Respondent's credit for the prior loss pursuant to Section 8(e)17; and

- 95% loss of use of the left arm under Section 8(e)10.

II. Cost of Handicap Accessible Housing

Pursuant to the parties' stipulation, the Arbitrator awarded a replacement handicap accessible home under Section 8(a) with the ruling on the cost of the home being deferred as the parties wished to resolve that issue by agreement. In the event they were unable to do so, the Commission would be asked to decide it. On January 17, 2018, Petitioner filed his Motion for Resolution of Housing Issue. Therein, Petitioner indicates the parties have been unable to resolve the cost issue and requests the Commission "establish the cost for his replacement handicap accessible home."

Having analyzed the evidence, the Commission finds there is insufficient information in the record to make this adjudication. The Commission first emphasizes the most recent plans are from 2010 and therefore are nearly a decade old. Further, Mr. Wisniewski testified, before any construction could begin, he would need to meet with Petitioner and revise the plans to meet the family's current needs. PX14, p. 99, 102. The Commission observes as of the plans' latest revision, there was a significant change in the gross square footage. The Commission also highlights the construction cost estimates are five years out of date ($225 - $250 per square foot as of 2013.) Moreover, these amounts are exclusive of the purchase price of a property. The cost of the underlying tract is obviously a necessary part of the cost calculation, yet there is no evidence in the record regarding property costs for potential build sites.

Any cost ruling the Commission makes on this record would be mere guesswork based on out-of-date and incomplete information. The parties' agreement to have the Commission resolve the issue would not render the resulting speculative order any less objectionable or unsustainable. *Deichmiller v. Industrial Commission*, 147 Ill. App. 3d 66, 74, 497 N.E.2d 452 (1986) (It is axiomatic that liability under the Act cannot be premised on imagination, speculation or conjecture but must be based solely on the facts contained in the record).

18IWCC0312

The Commission enters and continues the hearing regarding the award of the cost of handicap accessible housing. The Commission finds Respondent's liability for safe and accessible housing for Petitioner is apparent, and we are troubled by the years of delay in accomplishing that necessity. Nonetheless, we are bound by the record, and we are unable to render a reasoned, fact-based cost ruling on the evidence before us. We emphasize, though, this decision in no way bars Petitioner from proceeding on the Section 8(a) petition before Commissioner Coppoletti in the future, once all the relevant, necessary, and current evidence has been secured. To that end, the matter is set for status before Commissioner Coppoletti on June 21, 2018 at 9:30am.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed September 20, 2017 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $969.53 per week for a period of 644 weeks, that being the stipulated period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have credit for $627,541.94 in temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner statutory permanent total disability benefits of $969.53 per week for life, commencing on August 23, 2017, as provided in §8(e)18 of the Act, because the injuries sustained caused the permanent and complete loss of use of the right arm and the right leg. Commencing on the second July 15 after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $567.87 per week for a period of 200 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the 100% loss of use of the left leg. Respondent shall have credit for the prior award of 15% loss of use of the left leg pursuant to §8(e)17.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $567.87 per week for a period of 223.25 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused the 95% loss of use of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that the awards of 100% loss of use the right hand, 100% loss of use of the left hand, and 50% loss of use of the left foot are vacated.

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

18IWCC0312

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement.

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

DATED: MAY 21 2018

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

lec/mck

o-03/21/18

43

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

RYS, MATHEW
Employee/Petitioner

Case# **05WC018103**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

18IWCC0312

On 9/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
J BARRETT LONG
567 W LAKE ST 6TH FL
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
ARBITRATION DECISION
CORRECTED

MATTHEW RYS
Employee/Petitioner

v.

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

Case # 05 WC 18103

18IWCC0312

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 **August 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 **Award of handicapped accessible housing**

FINDINGS

On **4/18/2005**, 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 **$75,623.08**; the average weekly wage was **$1,454.29**.

On the date of accident, Petitioner was **39** 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 **$627,541.94** for TTD, **$0** for TPD, **$0** for maintenance, and **$15,000.00** for other benefits, for a total credit of **$642,541.94.**

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

ORDER

Respondent shall be given a credit of **$627,541.94** for TTD, **$0** for TPD, and **$0** for maintenance benefits, **$15,000.00** in PPD advances, for a total credit of **$642,541.94.**

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $**969.53**/week for **644** weeks, commencing **4/19/05** through **8/22/2017**, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Schedule injury
Respondent shall pay Petitioner permanent partial disability benefits of **$567.87**/week for **457.50** weeks, because the injuries sustained caused 100% loss of the ***right and left hands*** (**380** weeks), as provided in Section 8(e)(9) of the Act, and 50% loss of use of the left foot (**77.5 weeks**), as provided in Section 8(e)(11) of the Act.

Permanent Total Disability (Statutory) language
Respondent shall pay Petitioner statutory permanent and total disability benefits of $**969.53**/week for life, commencing **8/23/17**, because the injury caused 100% loss of the ***right leg*** and 100% loss of the ***left leg***, as provided in Section 8(e)18 of the Act,

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

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

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

David A. Kane
Signature of Arbitrator

September 20, 2017
Date

9/20/17

SEP 20 2017

cRe: Matthew Rys vs. Chicago Transit Authority
Date of Accident: April 18, 2005
IWCC No. 05 WC 18103

FINDINGS OF FACT

On April 18, 2005, Petitioner was employed by Respondent as a journeyman ironworker. (PX#15, p.5) He was assigned to work at the tracks near Wellington Street, taking down scaffolding that was used over the weekend. (*Id.at 6)* Petitioner was standing on the top of a CTA truck taking down planks that hung underneath the tracks and stacking those planks. (Id.) As he did this, Petitioner fell 12 to 18 feet onto the ground below and has no recollection of being conscious at the scene. (Id.at 6–7)

A. MEDICAL CARE

He was taken to Advocate Illinois Masonic Medical Center and was an inpatient there from April 18, 2005 through April 29, 2005. (Id.at 7, PX#1) His diagnosis was quadriplegia, blunt abdominal injury, unstable C2 fracture of the cervical spine, C7 spinous process fracture and respiratory failure. (Id.) He was placed on a ventilator and had a metallic halo head brace inserted at the C2 level of his cervical spine to stabilize the fracture. (Id.)

On April 29, 2005, he was transferred to Northwestern Memorial Hospital and came under the care of Dr. Giri Gireesan. (Id.at 8, PX#2, PX#3) Petitioner was admitted and remained there until May 20, 2005. (Id.at 8, PX#2) On May 10, 2005, Dr. Gireesan performed surgery

consisting of the placement of an anterior screw at the C2 level. (Id., PX#2, PX#3) On May 20, 2005, Petitioner was discharged from Northwestern Memorial Hospital to the Rehabilitation Institute of Chicago as an inpatient. (Id.at 8) He remained an inpatient at RIC from May 20, 2005 through September 14, 2005. (Id.) His primary physician at RIC was Dr. David Chen, who remains his primary doctor at present. (Id.at 8-9) While at RIC, Petitioner underwent extensive physical therapy, occupational therapy, psychiatric and psychological treatment. (Id.at 9, PX#4) During the course of his stay at RIC he developed pneumonia in June and July 2005. (Id.) He was eventually weaned off the ventilator and on September 12, 2005, the C2 halo was discontinued and Petitioner received a smaller brace call a Miami J collar. (Id.)

During the course of Petitioner's stay at RIC, he suffered from a urinary tract infection for 30 to 60 days. (Id.) Petitioner has had multiple urinary tract infections over the course of the last 10 years. (Id.at 9-10) Petitioner testified that he gets them at least annually. (Id.at 10)

Petitioner was discharged from RIC on September 14, 2005, with a power wheelchair, which he was evaluated to operate on a moderate independent level. (Id.at 10, PX#4) Petitioner was discharged at a dependent level for grooming, bathing, dressing, toileting and transfers from his chair, meaning that he required assistance. (Id.) He was discharged to his home with 24 hour, 7 day per week home healthcare. (Id.at 10–11, PX#4) Petitioner continues to require 24/7 nursing care on an ongoing basis. (Id.at 11) Petitioner suffered from spasticity issues while at RIC, and after his release. (Id., PX#4, PX#5) Dr. Chen discharged Petitioner from RIC with medication for pain caused by the spasticity and for depression. (Id.at 11, PX#4) After returning home, Petitioner began

outpatient therapy at the RIC Day Rehab Center in Homewood, Illinois. (Id.at 11, PX#5)

Respondent provided Petitioner with a wheelchair accessible van from MobilityWorks in 2005. That van caught fire in early 2016, and Respondent provided Petitioner a new wheelchair accessible van as a medical necessity in mid-2016, and that remains his current mode of transportation. (Id.at 12)

B. HOUSING

Prior to Petitioner's discharge from RIC to his home in September 2005, Respondent hired a contractor to make modifications to his home to allow him wheelchair access. (Id.at 13) Petitioner's house was a long and narrow, two story, row house, with a basement. (Id.at 13–14) Petitioner spent most of his home time prior to the accident on the second floor. (Id.at 13) Modifications to the home were needed to allow Petitioner to enter into the house in his wheelchair and to widen doorways and door frames. (Id.at 14) An elevator was eventually placed near the rear of the home from the driveway to an elevated deck which allowed Petitioner access to the back of his home. (Id.) Respondent also hired a company to make modifications to the bathroom on the first floor the house, including a shower that he could access with his wheelchair. (Id.) The modifications that were made to the bathroom led to drainage issues. (Id.at 14–15) The drain of the shower was higher than the floor, so the water would go elsewhere in the bathroom, which eventually damaged the main floor support joists of the house. (Id.at 15)

After the accident, Petitioner lost access to the basement and second story of his house. (Id.) He had a large garage on the premises, where he

spent time prior to the accident. (Id.) He was a mechanic before becoming an ironworker, and had tools in his garage to do side jobs if work was slow or unavailable due to weather. (Id.at 15–16)

Due to the main floor water damage in the house caused by the improper draining of the shower, Petitioner had a home inspection done on September 28, 2010 by Protech Home Inspections. (Id.at 15–16) A second home inspection was done about one week later by First Choice Inspectors, who had been hired by Respondent. (Id.at 16) The Protech report found multiple structural issues, including main floor sagging from the water damage, while also noting that Petitioner's wheelchair weighed 400 pounds. (PX#15, Group Exhibit 1) The First Choice report indicated that Petitioner's home was not suitable for permanent assisted living due to unstable areas causing an unsafe living environment, and recommended immediate relocation. (Id.) Based on these reports, Petitioner concluded he had to leave the home. (PX#15, p.17) Petitioner relocated to Glenwood, Illinois to a rental unit, where he paid the rent. (Id.at 17–18)

In July 2005, Petitioner, his wife and his family met with Leonard Wisniewski, an architect, while Petitioner was still at RIC. (Id.at 18) The purpose of the visit was to discuss either modifications to Petitioner's existing home or relocation to a more suitable home. (Id.at 19) Mr. Wisniewski later visited Petitioner's home, took measurements and prepared as-build plans showing the layout of the home. (Id., PX#14) Mr. Wisniewski eventually drafted plans for a handicapped accessible home for Petitioner and his family, including modifications and accommodations for his daughter, Elizabeth, who was born with spina bifida and walks with AFO braces on her legs and uses Canadian crutches to walk. (Id.at 19–20) Petitioner requested authorization from Respondent to have the house Mr.

Wisniewski drafted to be built, but as of the date of arbitration Respondent has not authorized the building of that, or any other, home. (Id.at 20)

In September 2013, the building which contained the condo he was renting in Glenwood went into foreclosure. (Id.at33) On September 13, 2013, Dr. Chen recommended that Petitioner be placed in an assisted living facility or nursing care facility for at least six months. (Id.) Dr. Chen made this recommendation because Petitioner had nowhere to go. (Id.) Petitioner instead ended up in a rented home in Tinley Park. (Id.at 34)

At the time of arbitration, Petitioner was living at an Extended Stay hotel in Lansing Illinois. (Id.) He was in the process of transitioning to a temporary house in Indiana that a family member was allowing him to use. (Id.at 20–21) In mid to late 2016, Respondent authorized modifications to be made to the house in Indiana, and those modifications were ongoing at the time of Petitioner's evidence deposition on June 28, 2017. Petitioner testified that his use of the Indiana house will be temporary, because his family member will be taking the house back from him at some point. (Id.at 23)

Petitioner testified that from 2005 to the present, there have been several instances where Petitioner and Respondent have had realtors looking for handicapped accessible homes for him throughout the Chicagoland area and Northwest Indiana. (Id.) Respondent has had their nurse case managers involved in the search process also. (Id.) Petitioner further testified that following a 2016 pretrial before Arbitrator Kane, Respondent authorized a realtor to search for available homes that could accommodate Petitioner and his family. (Id.) This realtor found homes that were acceptable to Petitioner and his family, but Respondent did not authorize the purchase of any of them. (Id.at 24) Petitioner testified that he

desires the Arbitrator to order Respondent to authorize and pay for a permanent home consistent with the recommendations of Leonard Wisniewski, either with new construction or in an existing dwelling. (Id.) Petitioner further testified that the dwelling he receives must also be able to accommodate his daughter special needs and the need for 24/7 nursing care. (Id.at 24–25)

C. BEELMAN PERMANENCY ISSUES

On March 11, 2011, Petitioner fractured his left tibia and fibula at home while transferring from his bed to his chair. (PX15,p.30) At that time, Petitioner had progressed in therapy to stand up hanging onto a pole, take a step and pivot. (Id.at 30) As he did this at home, he started to have a spasm, so he was going to sit back onto his bed because he had not pivoted yet. (Id.at 30) His nurse thought he wanted to go to the chair and pulled him away from the bed. (Id.) Petitioner fell into a squat on his left leg causing the injury. (Id.at 30–31) Petitioner was admitted to St. James Hospital (PX#10) and was eventually transferred to Northwestern Memorial Hospital the next day, where he came under the care of Dr. Scott Cordes. (PX#11) Dr. Cordes casted Petitioner's foot and leg and ordered physical therapy. (Id.at 31, PX#11) Petitioner completed his therapy in June 2012. (Id.at 32–33) He testified he never regained the ability to stand and transfer himself following this incident. (Id.at 37)

D. CURRENT ISSUES

Petitioner has no function or use of either of his legs. (Id.at 35) He uses his left arm to control his chair and tries to brush his teeth with assistance. (Id.) He is able to raise his left arm to shoulder level. (Id.) He

is able to use his left hand to operate his wheelchair. (Id.at 35–36) He is also able to use a cell phone with his left hand. (Id.at 36) He is unable to use his right arm other than to move it around the arm rest of his wheelchair. (Id.at 37) He has no use of the right hand. (Id.) With respect to his left ankle, he is not able to stand and transfer himself anymore as a result of his March 11, 2011 fall. (Id.at 37–38)

E. CROSS-EXAMINATION

Petitioner was injured on September 18, 1997 while working for Delgado Erection. (Id.at 42) He received a recovery of 15% loss of use of the left leg from that case. (Id.) Once Petitioner determined he was not going to be able to stay at his home due to the home inspection report conclusions, he stopped paying his mortgage (Id.at 47) and the house eventually went into foreclosure. (Id.at 43)

F. EVIDENCE DEPOSITION OF LEONARD WISNIEWSKI

Leonard Wisniewski is a licensed architect in Illinois. (PX#14,p.5) He was licensed in 1969. (Id.at 6) He drafted the home designs in the Zephyr case in 1989 before the Commission, which, like this case, also involved home modification for the claimant's disabled family member, in addition to the claimant. (Id.at 7) Mr. Wisniewski had foster children, four of whom were disabled and in wheelchairs, and he made modifications to his home to accommodate them. (Id.at 8) Mr. Wisniewski kept notes of his work with Petitioner, which are contained in deposition Exhibit #2. (Id.at 9-10) Mr. Wisniewski measured the interior and exterior of Petitioner's original home and took photographs. (Id.at 10–11) Those measurements and photographs are contained in deposition Exhibit #3. From those measurements, Mr. Wisniewski prepared as-built drawings to document Petitioner's existing house and to utilize that information in the preparation of recommendations for work that would need to be done to the existing

dwelling to make it suitable for Petitioner, his daughter, and other members of the family. (Id.at 11–12) The as-built drawings are contained in deposition Exhibit #4. Mr. Wisniewski identified Petitioner's daughter as a disabled person with spina bifida who spends the majority of time out of bed on crutches or in a wheelchair or crawling. (Id.at 13) Deposition Exhibit #9 contains notes from a meeting Mr. Wisniewski had at RIC with Petitioner and his family, Petitioner's attorney and Dr. Chen. (Id.at 14) The purpose of the meeting was to determine the kinds of physical needs Mr. Wisniewski needed to be concerned with in the design of spaces for Petitioner due to his disability. *(Id.)* Based on Mr. Wisniewski's evaluation of Petitioner's home and his assessment of the needs of the family from his various meetings, he formulated an opinion, to a reasonable degree of architectural certainty, that Petitioner's home was totally inaccessible for Petitioner's permanent assisted-living needs. (Id.at 20–21) Mr. Wisniewski's recommendation was to build or buy a house that was suitable. (Id.at 21)

That opinion was independent of the issues Petitioner was having with his house due to the water damage. Mr. Wisniewski testified that he had the opportunity to discuss with Petitioner, and inspect for himself, the issues concerning the bathroom water drainage in the house. (Id.at 26) He concluded that the pitch of the shower was incorrect, causing water to leak into the structural system, causing damage to the floor joist of the home. (Id.) He testified that if the drainage were to continue, it was highly probable there would be some sort of structural failure in the floor-joist system beneath the shower that could cause the floor to collapse. (Id.at 26–27) Mr. Wisniewski also reviewed the home inspection reports performed in September 2010 and October 2010. (Id.at 67) Based on his review of these reports, he did not feel that Petitioner's home was suitable and appropriate for Petitioner's family and their permanent assisted-living needs from a safety standpoint, and that it was appropriate for Petitioner to move out of the home. (Id.at 68–69)

Mr. Wisniewski drew up preliminary plans for a new home for Petitioner, using the same square footage in the new home as the existing home had, but including additional spaces needed for Petitioner to manipulate his wheelchair and his daughter to manipulate herself in her private bathroom. (Id.at 53–54) Mr. Wisniewski designed the house to accommodate Petitioner and his daughter as handicapped people, and the

two ambulatory members of his family, his wife and son. (Id.at 55) Those plans are contained in deposition Exhibit #23, and are dated July 23, 2007. The notes Mr. Wisniewski took from his meetings with Petitioner's family, upon which the preliminary plans were based, are contained in deposition Exhibit #21. Mr. Wisniewski eventually generated a report drawing together all of his meetings with Petitioner and his family, their needs, and the proposals for a new home, which are contained in deposition Exhibit #24. (Id.at 58) The report is dated March 31, 2008. (Id.at 59) Mr. Wisniewski concluded in the report that Petitioner and his family needed a new house, to a reasonable degree of architectural certainty. (Id.at 59)

Mr. Wisniewski testified that in addition to the existing needs of the family, additional space would be required for the 24 hour caregivers. Mr. Wisniewski made final revisions to his plans, which included a private bathroom for Petitioner's wife, which would give her privacy from Petitioner's caregivers and a private bedroom away from the caregivers since Petitioner and his wife did not sleep together. (Id.at 60) The revised plans are contained in deposition Exhibit #26. Mr. Wisniewski testified, to a reasonable degree of architectural certainty, that the plan contained in deposition Exhibit #26 represented a suitable and appropriate plan for Petitioner and his family for his permanent assisted-living needs and those of his daughter. (Id.at 62)

The home Mr. Wisniewski designed for Petitioner was 4383 gross square feet, roughly the same as his original house. (Id.at 64–65) He testified that the cost to build such a home would be between $225.00 and $250.00 per square foot, as of 2013. (Id.at 65–66) Mr. Wisniewski also identified a letter from Darren Buczkowski, one of the employees from Extended Home Living Services hired by Respondent to perform modifications on Petitioner's house. (Id.at 66) Mr. Buczkowski reviewed Mr. Wisniewski's preliminary drawings contained in deposition Exhibit #23, stated that the construction rate per square foot in 2007 would be $210.00 per square foot and approximately $60.00 per square foot for the garage, and estimated the cost to build the home contained in deposition Exhibit #23 to be $865,000.00. (Id.) Mr. Wisniewski testified that 6 years later, in 2013, the cost would have increased to approximately $225.00-$250.00 per square foot. (Id.at 66–67) Mr. Wisniewski later clarified on cross-examination that the cost he estimated was for the home alone, exclusive of the cost of

the garage and to buy the land. (Id.at 95) Including the cost of the garage and land, Mr. Wisniewski indicated on cross-examination that the total cost would be around $1,000.000.00. (Id.)

CONCLUSIONS OF LAW

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

1. Section (8)(e)(18): Permanent and total disability

Petitioner's treating physician, Dr. David Chen, prepared a report dated January 3, 2011. (PX#13) Dr. Chen indicated that Petitioner sustained a cervical spine fracture as a result of a work related injury which resulted in a cervical spinal cord injury and residual quadriplegia. He noted that Petitioner has a neurogenic bladder, neurogenic bowel and spasticity as secondary conditions. The quadriplegia has left Petitioner with impaired strength of his legs and no ability to stand or walk independently. He requires the use of a wheelchair for all mobility activities in his home and out in the community. Petitioner's neurogenic bladder is managed by the use of intermittent catheterization, and because of his lack of hand function, he requires physical assistance of a caregiver to perform the catheterization. Petitioner's neurogenic bowel is managed by a daily bowel program which involves the manual removal of stool and the insertion of a suppository because he is unable to move his bowels normally. Due to Petitioner's lack of hand function, he requires a caregiver to perform the entire bowel program, and hygiene following the evacuation of stool. Dr.

Chen concluded that the injury caused permanent and complete loss of use of Petitioner's legs, and complete loss of use and function of both hands.

Based on the foregoing, the Arbitrator concludes that Petitioner is statutorily permanently and totally disabled because the injury caused 100% loss of use of the right leg and 100% loss of use of the left leg, as provided in Section (8)(e)(18) of the Act.

2. "Beelman" Permanency

Petitioner alleges he is entitled to additional compensation under the Supreme Court's decision in Beelman Trucking v. IWCC, 233 Ill.2d 364 (2009). In that case, the Supreme Court held that the Act permits a worker to recover for the loss of two members under Section 8(e)(18) of the Act, as well as for any additional scheduled losses beyond the two losses compensated under that Section. (Id.at 380) In Beelman, the claimant suffered paralysis in both legs, paralysis below the shoulder of his left arm, and the surgical amputation of his right arm above the elbow. (Id.at 368) The Supreme Court upheld an award of statutory permanent and total disability benefits under Section 8(e)(18) for the loss of the claimant's legs, as well as the award of 235 weeks of permanent partial disability for the loss of the claimant's left arm and 250 weeks of permanent partial disability for the loss of the claimant's right arm, under Section 8(e)(10) of the Act. (Id.)

In the present case, Dr. Chen concluded that in addition to the permanent and complete loss of use of petitioner's legs, he also suffered the complete loss of use and function of both hands. This evidence was unrebutted by Respondent. Based on the foregoing, the Arbitrator awards Petitioner 190 weeks of permanent partial disability for the complete of use

5/20/17

loss of his left hand, and 190 weeks of permanent partial disability for the complete of use loss of his right hand, under Section 8(e)(9) of the Act.

Petitioner also fell at home in March 2011, causing left tibia and fibula fractures. Before the fall he was able to stand up from his bed with the assistance of a pole, pivot, and transfer himself to his wheelchair. Despite extensive physical therapy following this injury, Petitioner never regained the ability to support his weight allowing him to make these transfers. Based on the foregoing, the arbitrator awards petitioner 77.5 weeks of permanent partial disability because the injuries sustained caused 50% loss of use of the left foot, as provided in section 8(e)(11) of the Act.

O. OTHER: AWARD OF HANDICAPPED ACCESSIBLE HOUSING

The parties stipulate to an award of a replacement handicap accessible home as reasonable and necessary under Section 8(a) of the Act. The Arbitrator finds full support for the stipulation in the record. The Arbitrator notes the opinions of architect Leonard Wisniewski, whose testimony was unrebutted. The Arbitrator finds Mr. Wisniewski's testimony credible in all respects, and finds him well qualified to render architectural opinions for a disabled client, based on his personal experience with home modifications for his own disabled children and his long career of working with disabled clients, including the claimant in Zephyr v. Industrial Commission, 576 N.E.2d 1 (1991).

Mr. Wisniewski concluded to a reasonable degree of architectural certainty that Petitioner's original home was not suitable and appropriate for Petitioner, his family, and his permanent assisted-living needs. This opinion was twofold. From a practical perspective, Petitioner lost 2/3 of the

use of his residence as a result of this injury, including the portion of the home he spent the most time before the injury. From a safety perspective, based on the two home inspection reports and Mr. Wisniewski's own inspection the home, Petitioner and his 400# wheelchair were at risk from major structural collapse of the floor. Respondent's home inspector concluded the home was no longer suitable for permanent assisted-living, that unstable areas caused an unsafe living environment, and recommended immediate relocation.

Mr. Wisniewski also testified to a reasonable degree of architectural certainty that Petitioner and his family needed a new house, and he recommended Petitioner either buy a house that was suitable or build a house. He further testified that the plans contained in Exhibit 26 of his deposition represented a suitable and appropriate plan for the permanent assisted living needs of Petitioner and his disabled daughter, his family, and his caregivers.

The parties have agreed to have the Arbitrator defer his ruling on the cost of the replacement home and attempt to resolve that issue before the end of the calendar year. In the event the parties are unable to resolve that issue, they have agreed to reserve the right to litigate that issue before the Commission under Section 8(a) of the Act. The Arbitrator finds that the record contains an adequate basis to determine the cost of the replacement handicap accessible home, based on the testimony and architectural plans of Mr. Wisniewski and the report of Mr. Buczkowski, who was hired by Respondent.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Byron Rene Donis,
Petitioner,

vs.

NO: 08 WC 00798

Claudio L. Radu/Juan Carlos Hernandez &
Illinois Workers Benefit Fund,
Respondent.

18IWCC0313

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Claudio L. Radu herein and notice provided to all parties, the Commission, after considering the issues of jurisdiction and due process, vacates the Decision of the Arbitrator and remands the matter to the Arbitrator for trial on the merits with proper notice of the same.

STATEMENT OF FACTS

On June 8, 2016, an *ex parte* arbitration hearing was held before Arbitrator Gale. Present at this hearing were Petitioner, his attorney and the assistant attorney general representing the Injured Workers' Benefit Fund (IWBF). The Arbitrator noted neither Respondent Radu nor Respondent Hernandez were present or represented by counsel. T. 4. All issues were in dispute. T. 4. Petitioner submitted into evidence PX2, and the Arbitrator admitted the same. Petitioner's Exhibit 2 consists of a letter dated April 21, 2016 from Petitioner's attorney to Claudio L. Radu and Juan Carlos Hernandez mailed to 4914 N. California Avenue in Chicago. The letter indicated it was being sent via regular and certified mail. The letter was regarding Byron Rene Donis v. Claudio L. Radu/Juan Carlos Hernandez/State Treasurer, Case No. 08 WC 000798. The letter stated:

18IWCC0313

Dear Sir or Madam: Please be advised the above captioned matter appears on Arbitrator Gale's status call on June 2, 2016 at which time we will request a trial date of June 8, 2016. You must appear on June 8, 2016 at the Illinois Workers' Compensation Commission located at 100 W. Randolph Street, 8th Floor, Chicago, IL 60601 at the hour of 8:45 a.m. for hearing or an exparte [*sic*] – award may be taken against you. If you shall have any questions please contact me at your convenience. Very truly yours, Joel M. Bell.

Attached to this letter is a U.S. Postal Service Certified Mail Receipt indicating the letter was sent to Claudio Radu/Juan C. Hernandez located at 4914 N. California Avenue in Chicago, Illinois. Petitioner submitted into evidence PX1, and the Arbitrator admitted the same. Petitioner's Exhibit 1 consists of Certified Mail from Petitioner's attorney to Claudio L. Radu and Juan Carlos Hernandez located at 4914 N. California Ave in Chicago, the same envelope. On the envelope, the U.S. Post Office noted on April 22, 2016: "Return to Sender, Attempted – Not Known, Unable to Forward."

Further, in reviewing the file, the Commission takes judicial notice an Application for Adjustment of Claim was filed on January 8, 2008 naming Claudio Radu and Juan Carlos Hernandez as Respondents. The address identified for Juan Carlos Hernandez on said Application is 4914 West California, Chicago, IL, and the address identified for Claudio Radu is merely Chicago, IL.

The Commission also takes judicial notice that the arbitrator's decision of July 21, 2016 was mailed to both Claudio Radu and Juan Carlos Hernandez located at 4914 N. California Ave., Chicago, IL, 60625 which was returned as undeliverable. Thereafter, the Commission determined the address for Claudio Radu to be 1517 Lake Ave., Waukegan, IL, 60091, and the address for Juan Carlos Hernandez to be 245 Waukegan Rd., Lake Forest, IL, 60045. The July 21, 2016 decision was re-sent to the above addresses.

CONCLUSIONS OF LAW

On Review, Respondents Claudio L. Radu and IWBF argue no jurisdiction vested with the arbitrator as the *ex parte* hearing undertaken on June 8, 2016 was without proper notice to the parties. Respondent Claudio L. Radu argues the certified mailing offered into evidence does not verify any receipt of service nor does it identify a past or present address for Respondent Claudio L. Radu. Respondent Claudio L. Radu further argues the arbitrator's decision and the record in its entirety does not support a finding of proper notice of hearing being provided to Respondent Claudio L. Radu, and therefore, the resultant hearing on an *ex parte* basis unduly prejudiced Respondent Claudio L. Radu and deprived him of his due process rights.

In response, Petitioner argues Section 19(i) of the Act allows for service to be effectuated on the Respondent by filing such notice with the Commission when the Respondent has failed to file a current address with the Commission. As such, notice was properly effectuated.

The Rules Governing Practice Before the Illinois Workers' Compensation Commission provides for procedures to request a trial date certain. Specifically, Section 7030.20 in effect at the time in question states:

18IWCC0313

a) A written request for a date certain for trial may be made at the monthly status call on which the case appears. A request for a trial date in a case which does not appear on the monthly status call may only be made in accordance with Section 7020.60(b)(2)(B).

***

c) If there is no agreement:

***

3) The motions for trial dates shall be filed and heard pursuant to Section 7020.70 and Section 7020.60. If the Arbitrator determines that proper and timely fifteen (15) days notice was given of the motion for trial date to the opposing party, opposing party was provided with a completed Request for Hearing, said case appears on the monthly status call on the date the motion is heard, or if the case is not on the status call, the Arbitrator has determined that the case falls within the exceptions in Section 7020.60(b)(2)(B), and that the matter shall proceed to trial, the Arbitrator shall set the matter for trial on a date certain. If any party fails without good cause to appear, the Arbitrator will hear the motion for trial date ex parte, and if the Arbitrator determines the matter is ready for trial will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify the opposing party of the trial date.
50 Illinois Administrative Code 7030.20 (West 2007).

In addition, Section 7020.70 of the Rules provides the following:

a) Form of Motions

All motions, except motions made during an Arbitration or Review hearing, motions for a continuance of cases in the regular review call, and petitions filed under Section 19(h) and/or Section 8(a), must be accompanied by an Industrial Commission form entitled Notice of Motion and Order and must be served on the Arbitrator or Commissioner and all parties in accordance with subsection b). All such motions must set forth the date on which the moving party will appear before the Arbitrator or Commission and present the motion and must include the type of motion and nature of the relief sought.

***

b)1)(B) Motions for an immediate hearing under Section 19(b) of the Act and motions requesting a date for trial shall be served on the Arbitrator and on all other parties 15 days preceding the status call day set forth in the notice.
50 Illinois Administrative Code 7020.70 (West 2007).

The Commission finds Petitioner failed to properly follow the rules in requesting a trial date certain. There is simply no evidence Petitioner made any attempt to prepare and/or file a Motion for Trial Date nor any evidence a completed Request for Hearing form was prepared and provided to the Respondents. The only evidence in the record is a letter purportedly sent to the Respondents advising of Petitioner's *intention* to request the matter be set for trial on June 8, 2016. Such letter fails to comport

18IWCC0318

with the requirements set forth in the Rules to say nothing of Petitioner's failure to provide adequate notice to the Respondents.

The Commission further finds there is no evidence Respondent Radu was provided notice of the hearing much less notice of the filing of the Application for Adjustment of Claim. Petitioner filed the Application for Adjustment of Claim on January 8, 2008. Said Application notes two Respondents, Claudio L. Radu and Juan Carlos Hernandez. No address is provided for Claudio L. Radu, and an inaccurate address is provided for Juan Carlos Hernandez i.e. West California Ave. It is the obligation of Petitioner to provide the appropriate address. *See* 50 Illinois Administrative Code 7020.20(d) (West 2007). Given such, Petitioner's argument regarding notice pursuant to Section 19(i) of the Act is without merit.

The Commission finds Petitioner's failure to provide proper notice to the Respondents rendered the arbitrator's decision void. As the Supreme Court noted in *Interstate Contractors v. Industrial Commission*, 81 Ill. 2d 434, 438 410 N.E.2d 837 (1980), "the Industrial Commission and the circuit court are vested with the power to examine the validity of the decisions entered in the proceedings below and empowered to determine whether they are void for lack of jurisdictions over the parties." The purpose of providing notice and requiring a notice procedure to be followed is to allow both parties an equal opportunity to be made aware of an impending trial date so they may be able to present their respective side of the case on said date prior to a determination by the arbitrator. Further, the Commission finds requiring notice ensures due process under the law. The Commission finds due to lack of proper notice, there was no jurisdiction to conduct an *ex parte* hearing. Section 19 of the Act does not authorize the entry of a decision in violation of the principles of due process. *Interstate Contractors v. Industrial Commission*, 81 Ill.2d 434, 410 N.E.2d 837 (1980). Therefore, the Commission vacates the Arbitrator's July 21, 2016 decision and remands the matter to the Arbitrator for a new hearing on the merits with proper notice of same.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 21, 2016 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to arbitration for a hearing on the merits with proper notice of same.

DATED: MAY 21 2018

lec/maw
o-03/21/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

David L. Gore

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

Matthew Gasparovic,
Petitioner,
vs.

NO: 05WC 48261

Granite City Fire Department,
Respondent.

18IWCC0314

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 10, 2017 is hereby affirmed and adopted.

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

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

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

DATED: MAY 23 2018
o041618
KWL/jrc

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

GASPAROVIC, MATTHEW
Employee/Petitioner

Case# **05WC048261**
05WC048262

GRANITE CITY FIRE DEPARTMENT
Employer/Respondent

18IWCC0314

On 8/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0728 LAW OFFICES OF THOMAS W DUDA
330 W COLFAX ST
PALATINE, IL 60067

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

18IWCC0314

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
19(b)

Matthew Gasparovic
Employee/Petitioner

v.

Granite City Fire Department
Employer/Respondent

Case # 05 WC 48261

Consolidated cases: 05 WC 48262

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 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0314

FINDINGS

On the date of accident, **May 5, 2004**. 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*** causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$63,024.00**; the average weekly wage was **$1,212.00**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$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 of **$19,985.99** for medical bills paid through group insurance under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that his current condition of ill-being is causally related to his accident of May 5, 2004. All benefits are denied, including the prospective medical treatment requested by Petitioner; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit of **$19,985.99** for medical bills paid through group insurance under Section 8(j) of the Act.

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

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

Melinda M. Pope-Sullivan

Signature of Arbitrator

8/8/17

Date

ICArbDec19(b)

AUG 10 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Gasparovic
Employee/Petitioner

Case # 05 WC 48261

v.

Consolidated cases: 05 WC 48262

Granite City Fire Department
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Arbitrator notes at the outset that on June 27, 2017 in Collinsville, 05 WC 48261 was heard on an immediate hearing basis pursuant to a timely-filed 19(b) Petition, while 05 WC 48262 was tried on all issues.

Petitioner testified that in 2004, he was employed by the City of Granite City and that his rank was that of Captain at that time. He testified that his current status with the City was that of being retired and that he is on disability. He testified that he was first hired by the City in June of 1977 as an EMT. He testified that his duties during his early employment in 1977 were to respond to accidents and medical conditions in the City and area surrounding. He testified that when he was an EMT and a fire suppression call came in, he stayed outside and assisted the firemen in case they were overcome by smoke or were injured. He testified that the environment at a fire suppression call was chaotic and smoky. He testified that he performed his duties in all weather conditions. He denied wearing personal protective equipment as an EMT.

Petitioner testified that he became a firefighter in December of 1980. He testified that he became an Engineer in February of 1997 and that he became a Captain in June of 2004. He testified that his work hours when performing the duties of a firefighter were that of being on duty 24 hours and then off duty for 48 hours. He testified that when he was on duty, he lived at the station and that he ate his meals and slept there. He testified that he slept in the vicinity of the apparatus and that the apparatus in the station would include two firetrucks and an ambulance. He testified that at the downtown station, there were probably 3-4 fire trucks, three ambulances and other equipment generators. He testified that during his career from 1977-2004, he rotated throughout all three stations.

Petitioner testified that during his career, every day the Engineer would go through a checklist for daily maintenance and that additional weekly maintenance was performed as well. He testified that there were checklists for rescue vehicles and ambulances. He testified that the equipment was run inside the station with the door cracked and that there would be fumes including diesel exhaust and gas engine exhaust.

Petitioner testified that in April of 1985, something happened that took him off work. He testified that he was fighting a house fire. He testified that the fire extended into the garage and that next to the car was a burning cardboard-covered barrel full of trash. He testified that since the fire burned down the sides, he had to stick his hands underneath the bottom of the metal drum. He testified that since it was tight quarters he had to get his hands underneath like a forklift in order to raise it straight up and then twist to the sides. He testified that he felt a "pull" and hurt his back. He testified that he was off work initially until

September of 1985 and that he returned to work and suffered another injury to his back in December of 1986. He testified that he sustained injury to his low back when shoveling water to and from the fire truck and that he was a firefighter at that time. He testified that he was off work from that injury until February 10, 1997 and that he had surgery in April of 1997. He testified that on August 11, 1988, he applied for and was granted Line of Duty disability benefits.

Petitioner testified that he returned to work in February of 1997. He testified that he wanted to finish out his career on the fire service. He testified that he took a lot of tests and passed them all and that he returned as an Engineer. He testified that he worked as an Engineer until he suffered an injury to his left knee. He testified that he was an Active Captain for a lot of that time and that he did that for a great part of the time when he returned to work in 1997. He testified that he returned from disability in 1997 until October 27, 2002.

Petitioner testified that he had a left knee injury in October 2002. He testified that he underwent two surgeries to repair his left knee and that he was off work between the surgeries. He testified that he returned to work as a Captain after that and that he worked as Captain through November 2, 2004.

Petitioner testified that at a fire suppression scene, he would wear equipment that weighed 80 pounds. He testified that he wore his personal protective equipment when pulling hose and that he wore it in all weather conditions. He testified that he oftentimes left his mask on, but not have on the tank. He testified that as an Engineer, he was normally ordered to stay with the truck in order to protect the investment in the vehicle. He testified that this was not always the case and that he set it up as best he could and would try to assist the Captain with his tasks. He testified that he left his post sometimes and tried to help the Captain fight fires.

Petitioner testified that at the scene, he would be involved in activity to ventilate the roof. He testified that burning fires burn twice as hot now and that one had to get the poisonous gases out. He testified that he would take a ladder and make his way to the roof, and that hopefully another crew brought a fan to be set up by the door. He testified that the fan fired up and the hole in roof let the fumes out. He testified that he did not always wear a mask when climbing the roof for ventilation because the mask limited his vision. He testified that he kept it on his person but pulled it down out of his field of view. He testified that when the fire was extinguished, the overhaul procedure needed to be done. He testified that overhaul was the term for finding out what was still burning after the major flames went down and making sure the fire was extinguished and that there were no glowing embers or any fire left in the walls. He testified that overhaul included trying to determine the cause and origin of the fire. He testified that Captains were charged with this and usually had an Engineer as well. He testified that he did not wear a mask or filter of any kind while doing this.

Petitioner testified that he responded to emergency medical calls as well as both a Captain and an Engineer. He testified that he had responsibilities in carrying patients from the house to the ambulance and was involved in heavy lifting. He testified that he performed his duties in all weather conditions including extreme heat and cold. He testified that the personal protective equipment was highly insulated and that it was very hot inside, especially when it was hot outside. He testified that the frequency of fire suppression versus medical calls were about that of 80% for EMS or rescue or accidents and that the other 20% were for fire suppression.

Petitioner testified that he no longer smokes and last smoked in 2001. He testified that he quit in 1989, picked it up again in 1993 and quit again in 2001. He testified that he is diabetic and was diagnosed around 2000. He testified that he had elevated cholesterol at one time but that he has kept his numbers under control. He testified that there was a time when he had high blood pressure.

Petitioner testified that around April of 2004, he began noticing serious chest pains. He testified that they struck him as odd and that they were concerning. When asked what activities he was participating in when he noticed them, Petitioner responded that he was at a structure fire and that the pain that came on would not go away. He testified that his pain lasted for about 30 minutes and that he tried to shrug it off. He testified that he had seen a cardiologist, Dr. Speidel, before April of 2004. He testified that when he saw Dr. Speidel, he was not having chest pain and that the symptoms he reported to him was shortness of breath. He testified that he saw Dr. Speidel on two or three occasions and that he ordered a catheterization in 2002. He testified that he saw him one last time and that he indicated that he had adequate circulation. He testified that after the catheterization and angioplasty, he worked full-time.

Petitioner testified that in July of 2004 he was up on a roof and was chopping holes to help with ventilation. He testified that he started getting dizzy and had chest pain. He testified that he made it back down, went back to station and finished his shift. He denied filling out an Injured on Duty form. He testified that he continued working until September of 2004 when he was seen by a cardiologist in St. Louis. He testified that his heart was jumping and that he had angina pain whenever the alarm hit, that it started out only on occasion and that by the end of October it was happening 8-10 times per day. He testified that Dr. Greeling, his primary care physician, referred him to Dr. Kates. He testified that his first visit took place on September 22, 2004 and that after testing was performed, he was told to go to Barnes Jewish Hospital for catheterization which was performed on November 2, 2004.

Petitioner testified that after that catheterization in November 2004, he did not return to work. He testified that about an hour before he was released from the hospital Dr. Kates came in, said he had looked at the results and said he was not going to be a firefighter again. He testified that he has not performed his duties since November 2, 2004 and that he has continued treating with Dr. Kates. He testified that Dr. Kates ordered additional cardiac testing, including another stress test in May of 2009, an echocardiogram in 2009 and a cardiac MRI in 2009. He testified that he still takes medications. He testified that he always has nitroglycerin tablets with him in case of an angina attack. He testified that he takes three heart medications as prescribed by Dr. Kates.

Petitioner testified that he applied for pension fund benefits and that a hearing was conducted in 2006. He testified that he was awarded Line of Duty disability benefits.

Petitioner testified that he continued working through November 2, 2004. He testified that on May 5, 2004 while inspecting a laundromat, he got a call about an attempted suicide just blocks away. He testified that he jumped into the truck and got to the scene. He testified that en route there was a section of road that went over an old levy, that the truck went over, that because the front suspension was not repaired it "bottomed out" on the front axles and then sprung immediately back up causing Petitioner to hit the ceiling. He testified that he went back down into the seat sideways. He testified that he was shaken up but proceeded on to the house which was in view. He testified that he was able to talk the situation down. He testified that he returned to the station and started to realize that he had hurt his neck. He testified that he filled out an accident injury report, *i.e.*, Petitioner's Exhibit 2, and that it contained his handwriting. He testified that he filled out the report on May 5, 2004. He testified that he finished his shift and continued working, but that while working he experienced symptoms.

Petitioner testified that during the remainder of the year 2004, he did not see a doctor about his neck but admitted that he did see a physician about his cardiac condition. He testified that he tried to see Dr. Kennedy about his neck, that he went to his office at Missouri Baptist and that he made an attempt to see him. He testified that he went back after several months and tried again. He testified that he eventually saw a doctor in 2007-2008. He testified that his symptoms were a lot of pain in the back of the neck in the middle going downward and that he had pain in the shoulders, arms and hands. He testified that he was getting weaker as time went on. He testified that he attributed it to the chest pain and the pain radiating down his arms. He testified that as he started getting better with the heart medications, he expected the

pain to go away but it did not in his arms or shoulders. He testified that saw Dr. Wright, that he ran a test or two and that he said he had no surgical solution and recommended pain management. He testified that he saw Dr. Guarino, a pain management specialist, who did some steroid injections in his neck. He testified that the pain relief only lasted about 24 hours.

Petitioner testified that he eventually came under the care of Dr. Gornet. He testified that the pain was getting worse and that eventually in early 2010, he called on a chiropractor, Dr. Eavenson. He testified that he told him his hands would not function and that he could not pick up a paper clip. He testified that he mentioned Dr. Rotman, that he saw Dr. Rotman and that he did steroid injections in his wrists. He testified that the injections made no difference. He testified that after three sessions, Dr. Rotman asked him if he had problems with his neck, that he did x-rays and then referred him to Dr. Gornet. He testified that he saw Dr. Gornet in 2010 and that he ordered some more testing. He testified that Dr. Gornet said that he would need a triple disc operation. He testified that surgery was scheduled in September of 2010 but did not take place. He denied having refused the surgery. He testified that he wants to have the surgery by Dr, Gornet.

Petitioner testified that in 2002-2003, he saw Dr. Schoedinger. He testified that Dr. Schoedinger saw him, did an exam and indicated that he had over-rotated his head to get air while rehabbing his knee. He testified that he ordered testing, including an MRI of neck. He testified that after the MRI scan, Dr. Schoedinger only said he had mild to moderate arthritis.

Petitioner testified that his neck pain is horrible and constant, that he gets a couple of hours of sleep and that it severely limits his activities. He testified that when he cuts the grass, he used to be able to cut the front and back yard at one time but now has to split it up over two days. He testified that when he tries to cut the grass, he gets exhausted very easily and has to sit down and rest. He testified that climbing steps is difficult and that he limits the number of times he goes into the basement. He testified that he does not do household chores like he used to, including cleaning out the gutters or going on the roof.

On cross examination, Petitioner agreed that the last day he worked was November 2, 2004. He denied having been employed anywhere else since. He denied having looked for any type of employment. He agreed that when he was off work for his initial low back claim in the 1980's, he was off work until February of 1997. He testified that he attended college and has a Master's degree.

On cross examination, Petitioner testified that he received a pension beginning in the 1980's and lasting until February of 1997. He testified that he again applied for a pension after November 2, 2004 and that he was awarded that in 2006. When asked if from December 15, 1980 to November 2, 2004 he agreed that during that 20-year period he was working as a firefighter about 12½ years, Petitioner responded that he supposed so. He testified that he became a full-time Captain in June of 2004 and that when he returned to work in 1997 up until his knee injury in 2002, he was primarily classified as an Engineer.

On cross examination, Petitioner denied knowing the exact number of days that he was moved up to Acting Captain between 1997 when he returned to work and before his knee injury in late October 2002. He agreed that after he sustained the injury to his knee in late October 2002, he did not return to full duty as a firefighter until of January of 2004. He testified that during the calendar year 2003, he was on light duty most of the time at the station recuperating with his leg in a cast. He testified that within weeks after surgery, he was reporting to work 40 hours per week but was not able to respond to a call in 2003. He testified that he became a full-time Captain in June 2004 and that he was doing Captain duties from January 2004 onward.

On cross examination, Petitioner agreed that since November of 2004 he still gets some angina symptoms and that it occurs with activities of daily living. He agreed that while he was off full duty for his knee condition, he told his doctors that he had gained weight because he was less active. He testified that

he recalled telling Dr. Kates that his duties of a firefighter were beyond those of an average firefighter and that he told him that he fought fires alone for years.

On cross examination, Petitioner agreed that he had to do testing to make sure the trucks were functioning properly. He agreed that when he would start the truck to make sure it was operating properly, it would be pulled out of the house. He testified that when he checked to make sure the equipment was operating correctly, he would certainly try to do so outside of the house. He agreed that they would check the chainsaws once a week. He testified that they checked the breathing apparatus daily.

On cross examination, Petitioner testified that he would have reported his neck pain to Dr. Greeling. He denied recalling getting a written referral to a surgeon for his neck. He agreed that he never saw Dr. Eavenson until 2008. He agreed that in 2008-2010, the symptoms in his arms and hands had continued to worsen.

Kenneth Prazma was called as a witness by Respondent at the time of arbitration. He testified that he is employed by the Granite City Fire Department as the Assistant Fire Chief and has held the position since August of 2014. He testified that as Assistant Chief, he goes over EMS reports, takes care of inspections for the city, schedules vacations and helps to take care of some of the equipment.

Mr. Prazma testified that he started with the Granite City Fire Department on November 1, 1990 and that he was hired in as a firefighter. He testified that he was involved in fire suppression at the scenes. He testified that he worked as an Engineer until the time he was promoted to Assistant Chief. He testified that as an Engineer, he worked at three different houses. He testified that as an Engineer, he worked most at the downtown fire station. He testified that the job duties did not necessarily differ between the fire houses. He testified that the duties of an Engineer included starting at 7:00 a.m., checking the trucks, making sure the equipment was there, pulling out the trucks and checking the lights. He testified that they also went over the self-contained breathing apparatus ("SCBA") to make sure that they were full and that they also made sure their gas detectors and flashlights were working. He testified that they wore the SCBA anytime they entered a fire.

Mr. Prazma testified that when they arrived at a building or structure fire, the typical duties of the Engineer were to park and that when they pulled up, they would pull up at least one house past the initial fire. He testified that they were also responsible for getting the hoses prepared. When asked if he would typically enter a building that was on fire, Mr. Prazma responded that it depended. He testified that different stations responded to certain areas. He testified that the job duties after the building fire was put out included pulling tarps out to lay the SCBAs on. He testified that as an Engineer, he was typically not responsible for ventilating roofs if he was on the initial responding truck and that this would happen most likely if he was the second or third truck to arrive.

Mr. Prazma testified that Respondent's Exhibit 2 was Petitioner's work schedule throughout every year. He testified that he did not have access or the ability to locate any work schedules prior to 1999. He testified that the calendars were kept in the usual course of business. He testified that in 2001, 2002 and 2004, the days that were circled were where there were building fires and Petitioner's work day coincided.

On cross examination, Mr. Prazma agreed that if he was not the first truck on the scene to supply water, he would perform whatever duties were assigned by the Captain. He denied wearing a mask when operating the pump panel. He testified that it was possible that the area might be surrounded with smoke and fumes.

On cross examination, Mr. Prazma testified that in 2002 and 2004, Petitioner worked light duty as designated by "LD." He testified that there was not one day in 2003 that showed Petitioner having actually working. He agreed that he did not pull information pertaining to dumpster fires, grass or field fires or

rubbish fires. He agreed that it was accurate to say that the positioning of the truck was the number one priority of the Engineer. He testified that when starting tools in the winter, it was not customary to do it in the house and that they would do it outside even in colder weather.

David Vincent Martinez was called as a witness by Respondent at the time of arbitration. He testified that he is employed by Granite City and is currently the Fire Chief. He testified that he has been the Fire Chief since August 4, 2014. He testified that he was hired on September 1, 1987 as a probationary firefighter and that he was educated as an EMT. He testified that he was the first Fire Chief to sit as an active Paramedic. He testified that he was promoted to an Engineer in 2003, was promoted to Captain in 2008 and was promoted to Chief in 2014. He testified that he has worked at all three fire houses.

Mr. Martinez testified that as an Engineer, his primary responsibilities at a structure fire were to set up the truck and make sure nothing was in the way of the truck. He testified that they would pull one house past the structure, that the Captain finished the size-up, walked around and used radio communications to discuss strategy. He testified that as an Engineer, he did not regularly enter building fires.

Mr. Martinez testified that he could not recall a time when entering a structure fire without using the SCBA. He testified that when he first started, there were still some firefighters that embraced that mindset but that he never did. He testified that there were guys there that indicated that the SCBAs were a hindrance. He testified that as a Captain, the first function is rescue and that the second objective is to contain the fire or protect the exposures. He testified that as Captain he usually put on the SCBA while en route and that this was how they currently trained their employees. He testified that he was also involved with the maintenance of equipment and trucks. He testified that when checking gas-powered equipment, some might have started the equipment inside but that it was frowned upon.

On cross examination, Mr. Martinez agreed that during his career, there had been changes in the ventilation systems for diesel apparatus. He testified that they used to wash soot off the walls in the firehouses annually. He testified that Granite City was a "sooty city." He agreed that during his career, it was routine not to wear SCBA during overhaul activities.

As it pertains to 05 WC 48261, the Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

As it pertains to 05 WC 48261, the Injury Report was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. It was noted that Petitioner was riding en route to an emergency suicide attempt, that they hit a bump and that Petitioner and his driver were thrown to the ceiling of the cab striking their heads, and that both of their bodies fell downward to the seats, landing sideways and with a twisting compression. It was noted that the front suspension springs were worn out on pumper #2. (PX2).

As it pertains to 05 WC 48261, the medical records of Dr. Rodney Greeling were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on May 10, 2017, at which time it was noted that he was seen for a variety of issues including diabetes, fatigue and hypertension. The Review of Systems was noted to be positive for back pain and neck pain. At the time of the August 3, 2016 visit, it was noted that Petitioner was seen for diabetes, edema, fatigue and chronic conditions. It was noted that there was no change in Petitioner's neck. The Review of Systems was noted to be positive for neck pain. At the time of the October 25, 2013 visit, it was noted that Petitioner was seen for diabetes, GERD and hypertension. It was noted that Petitioner's neck was "bad" and that there was no change in the numbness/weakness of his arms. Petitioner's chronic conditions were noted to include cervicalgia, among other issues. The Review of Systems was noted to be positive for neck pain. At the time of the April 26, 2013 visit, Petitioner was seen for multiple issues including diabetes, GERD and hypertension. The Chronic Problems were noted to include cervicalgia. The Review of Systems was noted to be positive for back and neck pain. (PX3).

The records of Dr. Greeling reflect that Petitioner was seen on October 26, 2012, at which time it was noted that he was seen for multiple issues including GERD and diabetes. The Review of Systems was noted to be positive for neck pain. At the time of the April 25, 2012 visit, it was noted that Petitioner had no change in his neck pain and that he had severe pain in both arms. It was noted that Petitioner was still waiting to have surgery. At the time of the October 14, 2011 visit, it was noted that Petitioner still had ongoing neck pain and stated that he could do very little without pain. At the time of the April 15, 2011 visit, it was noted that Petitioner was upset that his neck surgery was cancelled and that he still had significant symptoms. It was noted that Petitioner needed help putting his shirt back on and that his left arm was worse. It was noted that Petitioner stated that he must use the Celebrex to get by and that he understood the risk of Celebrex with heart disease. At the time of the October 8, 2010 visit, it was noted that Petitioner was seen for pre-surgical clearance. It was noted that Petitioner was to have neck surgery soon and that he was already cleared by his cardiologist. It was noted that the severity of the neck pain was incapacitating, that the duration was years and that the problem had worsened. It was noted that the frequency of the pain was constant, that the location of the pain was the bilateral posterior neck and bilateral shoulders and that there was radiation of the pain to the bilateral upper arms. It was noted that Petitioner described the pain as aching, burning and sharp and that the associated symptoms included decreased mobility, difficulty sleeping, muscle spasm and weakness. (PX3).

The records of Dr. Greeling reflect that Petitioner was seen on March 27, 2009, at which time it was noted that he still had neck pain. It was noted that Petitioner spent most of the day laying down and that he had increased pain with standing/walking. It was noted that Petitioner had weakness/numbness of the arms and that he was upset because the neurosurgeon would not do surgery. It was noted that Petitioner stated that pain management cost too much and that it did not help and that he saw a chiropractor who told him he needed a cervical myelogram and needed to see a doctor at Barnes. It was noted that Petitioner had not scheduled to see him yet and that he wanted to lose weight first. It was noted that Petitioner moved his arms and head easily with the exam and talking. (PX3).

Included within the records of Dr. Greeling was a note dated August 28, 2014 from Dr. Andrew Kates at Washington University pertaining to a follow-up visit for coronary artery disease. It was noted that Petitioner continued to be limited in his activity with significant back and neck pain and that it left him in bed the better part of 20 hours a day and that he appeared to be significantly debilitated by it. It was noted that Petitioner stated that he was considering surgery but had no specific plans in place at that time. It was noted that Petitioner had asked about his candidacy for surgery and that given the stable nature of his symptoms and his unremarkable stress testing two years prior, Dr. Kates thought that Petitioner was at low risk for perioperative cardiac complication. Also included within the records of Dr. Greeling was a note dated August 20, 2012 from Dr. Kates, which indicated that Petitioner continued to struggle with chronic neck pain from an injury he sustained while working as a firefighter. It was noted that Petitioner was very sedentary at baseline, which he attributed to his chronic neck pain and that he stated that he was active only 4/24 hours of the day. (PX3).

Included within the records of Dr. Greeling was a note dated August 15, 2011 from Molly Rater, FNP, which indicated that Petitioner had chronic neck pain due to an injury he sustained as a firefighter and that he remained very focused on the impact that his neck injury had had on his life. It was noted that Petitioner was currently pursuing legal action because his insurance company was denying coverage for surgery. It was noted that Petitioner's mobility was significantly impaired and that he stated that he was on his back 20/24 hours per day and that he was unable to exercise, which was very distressing to him. Also included within the records of Dr. Greeling was a note dated August 2, 2010 from Dr. Ou at Washington University, which noted that Petitioner presented for a pre-operative cardiac evaluation. It was noted that Petitioner had been having neck pain for the past 6-7 years, was recently seen by Dr. Gornet a month ago and underwent a CT scan of the neck and planned to have surgery in September. It was noted that Petitioner complained of worsening bilateral hand and arm weakness since June and that he had had a Cardizem

injection to the bilateral wrists in April. It was also noted that Petitioner had been taking Celebrex for 2-3 months. Petitioner was noted to have been doing well from a cardiac standpoint and was given clearance to proceed with neck surgery. (PX3).

Included within the records of Dr. Greeling was a note dated May 15, 2017 from Dr. Sood at Washington University School of Medicine Lung Center, which noted that Petitioner felt that most of his breathing issues were related to deconditioning as he was relatively sedentary. It was noted that Petitioner blamed his sedentary lifestyle on a cervical neck fracture that resulted 13 years ago while he was working as a fireman and that he struggled to get worker's compensation to cover any surgeries and felt his neck pain severely limited his mobility. The assessment was noted to include, among other issues, motor vehicle accident with cervical neck fracture. (PX3).

The records of Dr. Greeling reflect that Petitioner was seen on April 23, 2008, at which time it was noted that he was 10 minutes late as always. It was noted that Petitioner was seeing pain management, had three epidurals and was no better. It was noted that Petitioner appeared in no acute distress and moved his neck with talking. It was noted that Petitioner had been seen by a neurosurgeon who did not feel that he needed surgery but that Petitioner "want[ed] it fixed." Included within the records of Dr. Greeling was a note from Dr. Wright in the Department of Neurological Surgery at Washington University School of Medicine dated January 23, 2008, which noted that he had reviewed the bone scan performed on January 22, 2008 at Barnes Jewish and that it did not show any abnormalities suggesting degenerative changes in the cervical spine either in the upper or lower aspects and that they did not have a good localization of Petitioner's neck pain. It was noted that without knowing which levels the pain was coming from, it was difficult to recommend a surgical treatment. It was noted that the best next step would be to try further injections higher in the neck and that hopefully Dr. Guarino would be able to sort out which level(s) were causing neck pain. (PX3).

The records of Dr. Greeling reflect that Petitioner was seen on August 17, 2007, at which time it was noted that he complained of neck pain. It was noted that Petitioner had seen a chiropractor and that per Petitioner he had had pain for three years from multiple injuries while working. It was noted that Petitioner had occasional left arm numbness and that x-rays revealed multilevel degenerative joint disease. At the time of the December 8, 2006 visit, it was noted that he was recently admitted at Barnes for dyspnea. It was also noted that Petitioner complained of neck pain and that he saw a neck specialist for it a few years prior. (PX3).

As it pertains to 05 WC 48261, the medical records of Anderson Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent cervical spine x-rays on April 16, 2007, which were interpreted as revealing (1) multilevel degenerative disc disease of the cervical spine, most pronounced at C5/C6 and C6/C7 level where it is moderate in severity and there is facet osteoarthropathy of bilateral C5/C6 facet joints; (2) no displaced fracture of the cervical spine and no listhesis. (PX4).

As it pertains to 05 WC 48261, the medical records of Belleville Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent an MRI of the cervical spine on October 1, 2008, which was interpreted as revealing no Chiari malformation, cervical syrinx or malignant-appearing focal marrow replacing process is seen; disc space narrowing is seen at C5-6 and C6-7; small ventral extradural deformities on the thecal sac are present at C3-4, C4-5, C5-6 and C6-7; STIR sequences fail to demonstrate evidence for suspicious marrow edema; endplate marrow change is observed adjacent to the left uncovertebral joint at C3-4; minimal central ventral extradural deformity on the thecal sac is present at C4-5; loss of uncovertebral joint degenerative and hypertrophic changes present at C5-6 and C6-7; no definite disk herniation or spinal canal stenosis is seen. The comparison study was noted to be that of September 12, 2007. Petitioner also underwent an MRI of the cervical spine on September 12, 2007, which was interpreted as revealing moderate cervical

spondylosis, greatest in the mid-cervical spine, with endplate osseous ridging and disc and uncovertebral and facet degenerative spurring, as well as apophyseal joint disease, with moderate narrowing of the central canal at C5-6 and associated severe bilateral foraminal narrowing. (PX5).

As it pertains to 05 WC 48261, the medical records of Barnes Jewish West County Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen for an Initial Evaluation of Dr. Anthony Guarino on January 10, 2008, at which time it was noted that his current problems began approximately three years ago at work while driving in the cab of a fire engine with poor suspension. It was noted that Petitioner's vehicle hit a pothole, that his body was jarred from the seat and that his head hit the ceiling of the cab. It was noted that Petitioner subsequently had pain at the base of the skull that had persisted since that time and that he had had pain in other areas of the neck in 2003, but had resolved in time. It was noted that Petitioner currently managed his pain with activity modifications and medications and that he noted he was only out of bed 6 hours per day due to the level of pain he was experiencing. It was noted that Dr. Wright was requesting diagnostic and potentially therapeutic injections in order to clarify what he may be able to offer Petitioner surgically. The impression was noted to be that of (1) cervical radiculitis; (2) cervical spondylosis. Bilateral C6 nerve root injections were performed. (PX6).

The records of Barnes Jewish West County Hospital reflect that Petitioner was seen on May 27, 2008, at which time it was noted that his chief complaint was that of neck pain to the bilateral shoulders to the bilateral arms. No relief was noted from the last visit. At the time of the May 21, 2008 visit, it was noted that Petitioner's chief complaint was that of neck and occasional shoulder and right arm pain and weakness. It was noted that Petitioner was frustrated. It was noted that Petitioner was there to clarify the discogram and that he recalled intense pain during the procedure, which he was not sure he communicated. At the time of the May 16, 2008 visit, it was noted that Petitioner's chief complaint was that of neck pain and that he felt a pulling at the base of his skull. It was noted that Petitioner had 0% relief from the bilateral C4 selective nerve root blocks performed on March 24, 2008. At the time of the March 24, 2008 visit, it was noted that Petitioner noted increased range of motion of his lower neck for 1-2 days. At the time of the March 6, 2008 visit, it was noted that Petitioner had no relief from the treatment performed on January 10, 2008 and that his chief complaint was that of neck and right arm pain. (PX6).

As it pertains to 05 WC 48261, the report of Dr. Michael Gross was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The report noted that at work on or about October 27, 2002, Petitioner was performing his duties as a firefighter and at that time was fighting a fully involved structure by himself in full gear. It was noted that Petitioner was pulling 200 feet of hose and could not get access due to a fence. It was noted that Petitioner tried to pull a slat loose and, after struggling a minute or two, a bystander tried to help him but instead caused him to fall backward, when the fence jerked. It was noted that Petitioner's left leg went into a hole and that he fell backwards, struggled back to his feet and then his knee gave way, causing Petitioner to fall a second time. It was noted that Petitioner had undergone two surgeries to the left knee. It was noted that in May of 2003, Petitioner was swimming, as suggested by his chiropractor, to treat his knee and that he began to have pain with rotation of his neck while swimming. It was noted that a couple of days later Petitioner was scheduled for work hardening, that he told the doctor about the pain and that he was told to continue swimming. It was noted that Petitioner's neck pain continued, that he went back to swimming and had excruciating neck pain, tearing and pressure and that his head felt like he could not move it. It was noted that Petitioner saw the chiropractor again and asked him to do something for his neck, but the chiropractor refused. It was noted that Petitioner saw Dr. Schedinger in September of 2003, that the doctor did an MRI and that the doctor told him to wait until his neck pain was unbearable because he would not operate more than once. It was noted that Petitioner again saw the doctor in August of 2003, and that his neck pain had improved around August of 2003. It was noted that Petitioner finished work hardening for his knee and returned to work on January 6, 2004 and that he returned to work for five months. It was noted that at work on or about May 5, 2004, Petitioner was

responding to an emergency, that the tire truck went into a deep pothole and that he was thrown upwards, hitting his head on the roof. It was noted that Petitioner felt immediate back and neck pain and that he did not see a doctor. It was noted that the pain became increasingly worse about a year ago beyond the point of tolerance and that he saw his doctor, who sent him for an x-ray. It was noted that Petitioner was told he needed an MRI and that the insurance company wanted him to see a chiropractor before he had an MRI. It was noted that Petitioner had manipulations and therapy and that his neck did not get better. It was noted that Petitioner took a muscle relaxer and the excruciating pain returned to his neck. (PX7).

The report of Dr. Gross reflects that at the time of the examination, Petitioner complained of left knee pain as well as neck pain. It was noted that Petitioner complained of neck stiffness and of sharp pain and burning in the right arm and shoulder. It was noted that Petitioner complained of headaches several times a week, that he complained of neck muscle tightness and constant popping and noise in his neck and that he complained that he had to lay down by late afternoon due to intolerable neck pain. It was noted that Petitioner called and added complaints that he could not raise his arm straight out beyond horizontal level mainly over the last year, and that he complained of pain in the upper half of his neck which he never had before his May 2004 injury. The diagnoses were noted to be that of (1) residuals of a soft tissue and ligament injury of the left knee; (2) residuals of a medial collateral ligament injury (post-operative state); (3) residuals of an anterior cruciate ligament repair (post-operative state); (4) residuals of a cervical spine injury. It was noted that Dr. Gross was of the opinion that Petitioner's present state of ill-being in the left knee and neck were causally related to the accident that occurred on or about October 27, 2002, that Petitioner had a major loss of use of the lower extremity and a major loss of use of the man as a whole and that Petitioner was disabled from firefighting as a result of the injuries. (PX7).

As it pertains to 05 WC 48261, the medical records of Professional Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent a CT of the cervical spine with intrathecal contrast on June 28, 2010, which was interpreted as revealing advanced multilevel degenerative change with greatest canal, end plates and neuroforaminal narrowing at C5-C6. (PX8).

As it pertains to 05 WC 48261, the medical records of Dr. Mitchell Rotman were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on June 29, 2010, at which time it was noted that the FCR injection in the left wrist had helped quite a bit and that the big problem was the neck. It was noted that Petitioner had an EMG which showed numerous findings with Dr. Phillips and that he had multilevel bilateral chronic cervical radiculopathy involving C5, 6, 7 and possibly C8. It was noted that Petitioner had possibly mild diabetic neuropathy and that he also noted relatively mild median neuropathies across the carpal tunnels and ulnar neuropathies across the elbows. The impression was noted to be that of "pretty significant neck arthritis" possibly post-traumatic from his neck injury a few years ago noted at the last visit. Petitioner was recommended to discuss these issues with Dr. Eavenson and decide if surgical treatment was going to be required. It was noted that Dr. Rotman did not feel that the carpal tunnel release was going to be a major help to him or anything with the cubital tunnel as tests for carpal and cubital tunnel on that date were negative. Petitioner was instructed to return as needed. (PX9).

The records of Dr. Rotman reflect that Petitioner was seen on June 24, 2010, at which time it was noted that he had left volar wrist pain, more so than the right. It was noted that Petitioner had had two injections for FCR tendonitis on the right that seemed to have helped. It was noted that another main concern was Petitioner's neck. It was noted that Petitioner had a bad accident many years ago, that he had a colleague in the accident when they were ejected vertically to the roof that required a partial neck fusion and that Petitioner never had any surgery for it but had had several bouts of pretty significant neck pain. It was noted that Petitioner was concerned he had an Arnold-Chiari malformation from it. It was noted that neck x-rays showed pretty significant arthritic changes at C5-6, that Petitioner also had some changes at C6-7 and that it looked like he had an old C5 spinous process fracture avulsion (clay shovelers fracture).

Petitioner's left wrist at the FCR sheath was injected on that date. Petitioner was recommended to undergo an MRI of the neck to include the base of the brain and also an EMG to rule out cervical radiculopathy. At the time of the May 20, 2010 visit, it was noted that Petitioner had right FCR tenosynovitis of his wrist, that it was injected at the last visit and that it helped for about a week. It was noted that the pain was not as bad but that Petitioner wanted to have another round of injections. It was noted that the working diagnosis was FCE tendinitis based on the MRI scan. It was also noted that Dr. Rotman agreed that the second injection might be of some benefit. The injection was performed on that date and it was noted that Petitioner had a wrist support to wear. (PX9).

The records of Dr. Rotman reflect that Petitioner was seen on April 19, 2010, at which time it was noted that he was a personal friend of Dr. Eavenson and that both he and Dr. Eavenson went through some EMT training for the fire department 30 years ago and had remained friends ever since. It was noted that Petitioner was a retired firefighter and was complaining of right wrist pain after drinking a three-liter bottle of drinking water that was an awkward container without a handle. It was noted that Petitioner was also complaining of pain radiating into the thumb, index and part of the middle fingers and that he had had some issues with the left hand but that those had gotten better. It was noted that Petitioner stated his pain was extreme upon awakening and subsided after 3-4 hours, but also remained consistent throughout the day at a moderate level. It was noted that Petitioner had had problems with it for about two weeks without improvement on its own. It was noted that the working diagnosis was flexor carpi radialis tendinitis of the right wrist. An injection was performed and Petitioner was instructed to wear a brace for comfort over the next few days. (PX9).

Included within the records of Dr. Rotman was a Patient Consultation Visit dated June 29, 2010 from Dr. Phillips pertaining to consultative electrical diagnostic studies to evaluate neck and bilateral upper extremity pain and numbness. The History of Present Illness noted that Petitioner described a 6-year history of aching neck pain that had been gradually progressive since May 2004 and that he described the recent development of intermittent numbness in the thumb and index fingers, worse on the right side. It was noted that Petitioner had sharp/aching upper extremity pain, but clear radiation was not described. The bilateral upper extremity EMG nerve conduction studies were interpreted as revealing significant multilevel bilateral chronic cervical radiculopathy involving C5, 6, 7 and probably C8; relatively mild median neuropathies across the carpal tunnels and ulnar neuropathies across the elbows that may be a consequence of an underlying diabetic neuropathy; further evaluation with a lumbar CT and lower extremity electrical diagnostic studies would allow for clarification and further insight into the upper extremities results. (PX9).

As it pertains to 05 WC 48261, the medical records of Mark Eavenson, D.C. were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner was seen on September 8, 2014 for neck pain and bilateral upper extremity pain. It was noted that Petitioner saw Dr. Gornet and was scheduled for a CT myelogram on November 3rd. It was noted that Petitioner stated that he continued to have neck pain with pain in both upper extremities with weakness. At the time of the September 12, 2014 visit, it was noted that Petitioner stated that Petitioner stated that he felt about the same. It was noted that Petitioner had ongoing chronic neck pain and numbness in both upper extremities. It was noted that Dr. Eavenson spoke with Dr. Gornet and that Petitioner would be seen on Friday to discuss surgery options and costs. At the time of the August 19, 2014 visit, it was noted that Petitioner was asked to come in so that Dr. Eavenson could tell him that he spoke with Dr. Gornet. It was noted that Dr. Gornet was going to perform a 3-level disc replacement. (PX10).

The records of Dr. Eavenson reflect that Petitioner was seen on August 18, 2014, at which time it was noted that he had spoken with his attorney and that settlement was on the table. It was noted that Petitioner still needed surgery and that he was wondering if Dr. Eavenson would speak with Dr. Gornet to see if he would still be willing to do the surgery. At the time of the August 13, 2014 visit, it was noted that Petitioner had been made an offer to settle his work injury case and that he was there to discuss not only that but to discuss plans for surgery after the settlement. It was noted that Dr. Eavenson told Petitioner that

he should accept the offer and then move on with his life and get his surgery done through his private health insurance. It was noted that Petitioner stated that he was hoping that the surgery would change his life. It was noted that Petitioner was going to speak to his attorney and would get back to him to get set up for surgery. (PX10).

The records of Dr. Eavenson reflect that Petitioner was seen on September 1, 2011, at which time it was noted that he had been scheduled to see Dr. Gornet on November 14th and was to have an updated MRI. It was noted that Petitioner was still miserable and continued to have neck pain with pain in both upper extremities. At the time of the August 4, 2011 visit, it was noted that Petitioner had been evaluated by Dr. Lange, who noted that his condition was pre-existing. It was noted that Petitioner was still having considerable pain daily and that it had affected every component of his life. It was noted that Petitioner had weakness of both upper extremities and had atrophy. It was noted that Dr. Eavenson was going to speak to Dr. Gornet. (PX10).

The records of Dr. Eavenson reflect that Petitioner was seen on September 9, 2010, at which time it was noted that traction was actually aggravating his neck pain. It was noted that Petitioner was scheduled for surgery next month. At the time of the September 8, 2010 visit, it was noted that Petitioner stated that the traction aggravated the shoulder and arm pain temporarily but that he felt better that day. It was noted that Petitioner wanted to get another shot and was still very uncomfortable. It was noted that Petitioner's motion was still restricted, that he was still weak and that rehab continued including traction. At the time of the September 7, 2010 visit, it was noted that Petitioner saw Dr. Gornet and that surgery was scheduled for October 19, 2010. It was noted that Petitioner wanted to try some traction and therapy to relieve his pain. At the time of the July 22, 2010 visit, it was noted that Petitioner saw Dr. Gornet who had recommended a three-level artificial disc replacement. It was noted that Petitioner continued to have neck pain with pain in both upper extremities and that he wanted Dr. Eavenson to send a letter to his attorney to see if there was any way it could be paid under worker's compensation insurance because it was part of his work injury. It was noted that Dr. Eavenson spoke to Dr. Gornet and that he was going to contact the lawyer as well. (PX10).

The records of Dr. Eavenson reflect that Petitioner was seen on June 29, 2010, at which time it was noted that the cervical myelogram revealed multilevel degenerative changes, hypertrophic spurring and cervical disc protrusion. It was noted that Dr. Eavenson was going to send Petitioner to Dr. Gornet. At the time of the June 24, 2010 visit, it was noted that Petitioner saw Dr. Rotman and had a couple of injections with no significant relief. It was noted that Petitioner was still having bilateral upper extremity numbness and tingling and that Dr. Rotman had recommended an MRI of the cervical spine to rule out cervical radiculopathy as well as nerve conduction studies. It was noted that after a long discussion, Dr. Eavenson had convinced Petitioner to undergo a myelogram. At the time of the April 19, 2010 visit, it was noted that Petitioner had complaints of right wrist pain. It was noted that Petitioner stated that he had had this for 3-4 weeks after lifting something at home. It was noted that Petitioner was referred to Dr. Rotman for consideration of cortisone injection. (PX10).

The records of Dr. Eavenson reflect that Petitioner was seen on September 30, 2008, at which time it was noted that he had last been seen several years prior. It was noted that a 35-minute discussion had been had regarding the problems that Petitioner had been experiencing with his headaches, neck and knee pain and that Petitioner was going to talk to his lawyer to see if he could have treatment in Dr. Eavenson's office. It was noted that Dr. Eavenson recommended that Petitioner have an MRI of his brain as well as a myelogram. It was noted that Petitioner hugged Dr. Eavenson when he left and was very pleased he went there, and that he stated that he should have gone there a long time ago instead of going to Dr. King. (PX10).

As it pertains to 05 WC 48261, the medical records of Dr. Matthew Gornet (*i.e.*, July 1, 2010 through November 14, 2011) were entered into evidence at the time of arbitration as Petitioner's Exhibit 11A. The records reflect that Petitioner was seen on September 5, 2014, at which time it was noted that

he had not been seen since 2011. It was noted that Petitioner's main complaints were neck pain to both sides and both trapezius into his shoulders with tingling into both hands, right greater than left. It was noted that in the past, surgical treatment had been recommended at C4-5, C5-6 and C6-7. It was noted that Petitioner's case was settled and that he wanted to potentially move forward with treatment. It was noted that there was a possibility of fusion in the cervical spine, either limited at one level versus potentially a single level disc replacement. It was noted that Petitioner's symptoms seemed to be more at C5-6 and that Dr. Gornet wanted a CT myelogram before they developed a formal surgical treatment plan. It was noted that Petitioner had pain and symptoms that affected all aspects of his left and his quality of life, that he had obvious motor deficit with spinal cord compression and that he had failed conservative measures and wanted to move forward with treatment. (PX11A).

Included within the records of Dr. Gornet was an interpretive report for an MRI of the cervical spine performed on September 5, 2014, which was interpreted as revealing (1) mid cervical dextro curvature with multilevel discogenic and facet degenerative changes throughout the cervical spine, progressed/increased from November 14, 2011; (2) broad based disc bulge with variable degrees of bilateral moderate to severe foraminal encroachment from C4/5 to C7/T1, associated with moderate central canal spinal stenosis at C4/5 and C5/6 and increased from November 14, 2011; (3) C3/4 broad based disc bulge with left greater than right moderate foraminal encroachment, relatively unchanged; (4) C2/3 right lateral disc bulge and resulting right mild to moderate foraminal encroachment. (PX11A).

The records of Dr. Gornet reflect that Petitioner was seen on November 14, 2011, at which time it was noted that he had a significant problem and that the plan was disc replacements at 4-5, 5-6 and 6-7 with foraminotomies 5-6, 6-7 right, 4-5 and 5-6 left. It was noted that Petitioner understood that Dr. Gornet could not "fix all of his pain." It was noted that Petitioner wished to try to move forward with surgery and was going to arrange the finances for it. At the time of the August 11, 2011 visit, it was noted that Petitioner continued to have pain which affected his quality of life, neck pain into both shoulders, down his right arm into his hand and down his left arm into his forearm. It was noted that Dr. Gornet believed that Petitioner would require microdiscectomy and disc replacement at C4-5, C5-6 and C6-7 with foraminotomy at C5-6 and C6-7 right, and C4-5 and C5-6 left. It was noted that Petitioner was miserable and that his worker's compensation case was being evaluated. It was noted that Dr. Gornet continued to believe that it was causally connected to the work injury of May 5, 2004, that prior to this Petitioner had been told there was nothing that could be done with his neck and that subsequent to this he had heart problems and did not seek treatment immediately. It was noted that Petitioner's explanation was plausible to Dr. Gornet. (PX11A).

The records of Dr. Gornet reflect that Petitioner was seen on September 2, 2010, at which time it was noted that he understood a portion of his right arm pain may not completely improve and may require supplemental posterior foraminotomy at C7-T, but that Dr. Gornet believed that from a risk-benefit standpoint it was probably best to leave the C7-T1 level alone. It was noted that Petitioner's pain was so disabling to him that he desired to proceed. It was noted that Petitioner had been given a tentative surgery date and that he remained temporarily totally disabled. At the time of the July 1, 2010 Initial Spine Examination, it was noted that Petitioner presented with the chief complaint of neck pain, to both sides, to the base of his neck, headaches, cramping into both shoulders and burning pain down both arms into the hands and thumbs. It was noted that Petitioner's right side was worse than the left and that he stated that the problem began on May 5, 2004. It was noted that Petitioner was a captain, was riding in the fire truck to a fire, that the front suspension of the fire truck was broken and that they went over a rise and slammed down hard, causing Petitioner and a co-worker to be propelled up striking their heads on the ceiling of the cab. It was noted that Petitioner's co-worker ultimately underwent a three-level cervical fusion and that Petitioner had had intractable pain which had affected his quality of life ever since. It was noted that Petitioner returned just subsequently afterwards because of a heart problem but had continued to have pain which affected all aspects of his life and that it was constant and worse with any activity such as sitting, standing, bending or lifting. It was noted that Petitioner stated that he spent most of the day in bed because

of his neck pain and symptoms. It was noted that Dr. Gornet believed that Petitioner's current symptoms were causally connected to his work injury. It was noted that Petitioner would require treatment of the discs at C5-6, 6-7, potentially C7-T1 with a foraminotomy on the right at 5-6, 6-7 and potentially C7-T1, and that on the left he would require treatment at C5-6. An MRI was ordered and Petitioner was asked to undergo medical clearance. It was noted that Petitioner remained retired so work was not an issue, but that he was temporarily totally disabled. (PX11A).

Included within the records of Dr. Gornet was an interpretive report for an MRI of the cervical spine performed on November 14, 2011, which was interpreted as revealing (1) multilevel cervical spondylosis with disc/osteophyte complexes creating central stenosis at C4-5, C5-6 and to a lesser degree C6-7 with varying degrees of foraminal stenosis, probably most prominent at C5-6 bilaterally and C6-7 on the right; (2) left lateral defect C3-4, slightly more than previous, but could affect the left C4 root as it exits. (PX11A). Also included within the records of Dr. Gornet was an interpretive report for an MRI of the cervical spine performed on September 2, 2010, which was interpreted as revealing (1) circumferential disc bulging and endplate spurring at the C4-5, C5-6 and C6-7 and to a lesser degree C7-T1 levels; there is bilateral foraminal stenosis at each of these levels, severe at C5-6 and C6-7; moderate to severe at C7-T1 and severe on the left at C4-5; there is mild central canal stenosis at the C5-6 level; (2) left lateral recess/foraminal disc herniation at C3-4 with associated left-sided facet arthrosis resulting in moderate left foraminal stenosis at this level; there is no central canal stenosis here. (PX11A).

As it pertains to 05 WC 48261, the medical records of Dr. Matthew Gornet (*i.e.*, May 22, 2015 through June 4, 2015) were entered into evidence at the time of arbitration as Petitioner's Exhibit 11B. The records reflect that Petitioner was seen on June 4, 2015, at which time it was noted that he had a high-grade sarcoma in his bladder, was being treated and was now on Medicare. It was noted that Dr. Gornet's concern was that Petitioner needed to get his health in order and that if they needed to treat him, Dr. Gornet would attempt to get some donations to help defray the expenses. At the time of the November 3, 2014 visit, it was noted that Petitioner's CT myelogram clearly showed significant issues at C4-5, C5-6 and C6-7, that he had some foraminal stenosis at C3-4 on the left but that the majority of his symptoms were neck pain to the base of his neck, headaches, bilateral trapezial and bilateral shoulder pain, particularly the right shoulder and right arm, and also some left arm symptoms. It was noted that Petitioner did not have enough facet arthritis to warrant a certain fusion, but that he understood that it was possible that he may require a fusion to adequately treat all of his problems. It was noted that approval would be sought for C5-6 disc replacement and that Petitioner understood that they may also have to treat the other levels. (PX11B).

As it pertains to 05 WC 48261, the May 22, 2015 Letter from Dr. Matthew Gornet was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The letter dated May 22, 2015 was directed to Petitioner's attorney and addressed anticipated charges for various procedures that were recommended. (PX12).

As it pertains to 05 WC 48261, the transcript of the deposition of Dr. Matthew Gornet taken on January 27, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. Dr. Gornet testified that he is a board-certified orthopedic surgeon whose practice is devoted to spine surgery. He testified that he first saw Petitioner on July 1, 2010, at which time he noted that he was a 60-year-old man whose main complaint was that of neck pain to both sides at the base of his neck, cramping in the shoulders and burning pain down both arms into the hands and thumbs, and that the right side was worse than the left. He testified that Petitioner stated that he felt his problem began on or about May 5, 2004 when he was riding in a fire truck, that apparently the suspension of the fire truck was broken and that he went over a rise and slammed down hard causing he and a co-worker to be pushed up and down, striking their heads into the ceiling and then coming down onto the seat. He testified that Petitioner stated that he had intractable pain which had affected his quality of life ever since, that he had retired subsequently afterwards because of a heart problem but had had continued pain which affected his quality of life. He testified that Petitioner stated that the pain was constant and worse with almost all activities, sitting, standing, bending and lifting.

He testified that Petitioner stated that he spent most of his day in bed because of his neck pain and symptoms. that he had had an MRI. that he had had injections in the past and that he had seen Dr. Brown and Dr. Eavenson. (PX13).

Dr. Gornet testified that based on his review of the history and the films, his diagnosis was that of cervical radiculopathy and discogenic neck pain. He testified that he ordered an MRI and asked for medical clearance because of Petitioner's heart condition. He testified that Petitioner was medically cleared from his cardiologist and that they were attempting to get approval for surgery, which was that of a three-level disc replacement C4-5, C5-6 and C6-7. (PX13).

Dr. Gornet testified that he saw Petitioner on two occasions, July 1, 2010 and September 2, 2010. He testified that as of the first visit on July 1. 2010 if he were not retired. based on Petitioner's neck alone he did not believe that he would be capable of the duties of a firefighter. He testified that this would also be true for the second visit that he had with Petitioner as well. (PX13).

Dr. Gornet testified that he was aware that Petitioner had had some prior treatment to his neck. He testified that it was his opinion that Petitioner had pre-existing problems with his neck including disc degeneration and foraminal stenosis and that there was no indication that he had that Petitioner was sufficiently symptomatic. He testified that he believed that the accident aggravated the condition and that the condition had been symptomatic. He testified that due to a lot of medical reasons and other issues, Petitioner had never had treatment but that he was "essentially miserable." (PX13).

Dr. Gornet testified that he was not aware that Petitioner had attempted to seek care with Dr. Kennedy approximately in the year 2006 and could not get in to see him. He testified that it did not in any fashion alter his causation opinion. He testified that if Dr. Kennedy would not see him without approval from worker's compensation, it would be a reason for Petitioner to not be able to get medical attention but it would be consistent with an ongoing problem since the accident. (PX13).

On cross examination, Dr. Gornet testified that he did not have any medical records summarizing or describing treatment that Petitioner had received for cervical problems prior to the initial consultation with him on July 1, 2010. He testified that he subsequently received medical records as well as the IME report of Dr. Lange from Petitioner's attorney. When asked when Petitioner first sought medical treatment for cervical complaints following the reported injury of May 5, 2004, Dr. Gornet testified that it depended on what one described as cervical complaints because he believed that there was a portion of Petitioner's chest pain/shoulder symptoms which he initially sought treatment for that was actually cervical radiculopathy and was superceded by his heart condition and to some extent was missed. He testified that if one excluded those records, he believed that the history given to him was 2006 and then 2007. (PX13).

On cross examination, Dr. Gornet testified that there was a visit dated September 27, 2006 in Dr. Kates's notes that referenced an episode of chest pain that he believed was a cervical radicular complaint. He testified that the earliest note that he saw was that of November 2, 2004 with Dr. Kates where Petitioner was noted to be experiencing chest discomfort and chest shortness of breath for the past month. He testified that there was no mention of cervical complaints specifically in the notes of Dr. Kates from November 2, 2004 through September 27, 2006. He agreed that he did not have any indication that Petitioner sought any treatment for cervical complaints between the incident of May 5, 2004 and at least November 2, 2004 where he was seeing Dr. Kates for cardiac conditions. (PX13).

On cross examination, Dr. Gornet agreed that if the MRI of August 25, 2003 showed multiple extradural defects most prominent at C4-5, C5-6 and C6-7 accompanied by large disc abnormalities, severe compromise of the right neurocanal at C6-7 and prominent compromise of C5-6 neurocanals bilaterally, this would be consistent with the results of the myelogram and post-myelographic CT scan that was

performed on June 28, 2010. He agreed that Petitioner's condition involving the cervical spine was a progressive degenerative condition. (PX13).

On cross examination when asked to assume that there was no medical treatment after the May 5, 2004 incident until sometime in late 2006 or early 2007 and whether that would call into question a history of intractable pain in the neck since on or about the injury of May 5, 2004, Dr. Gornet responded that it was his understanding that Petitioner stopped working as a firefighter in November of 2004 and that he stopped working because of his neck completely in 2004 and was never appropriately diagnosed. He testified that it was his understanding that Petitioner continued to work in his regular capacity as a firefighter between May 5, 2004 and when he discontinued working on November 2, 2004 as a result of a cardiac condition. When asked if that would suggest that Petitioner was not in any intractable pain in the cervical region between May and November 2004, Dr. Gornet responded that the note in November of 2004 stated that he had a history of chest pain dating back at least a month so that it was a problem that was persistent at least a month or more before that. (PX13).

On cross examination, Dr. Gornet denied that it was his testimony that a classic cervical radiculopathy would be either identical to or consistent with chest pain or angina. He denied that the fact that the positive work-up for the cardiac condition would suggest that Petitioner's complaints of chest pain or angina were directly or only as a result of the cardiac condition and testified that it meant that a portion of the symptoms were attributable to the cardiac problem that was seen. He agreed that in terms of any further work-ups, testing or treatment involving the cervical spine, this occurred in late 2006 or into 2007. He agreed that this was 2½ years or more after the incident. (PX13).

On cross examination, Dr. Gornet testified that he did not have the films from the 2003 MRI but that he had the report from 2003, which was essentially the same as the one in 2010. He agreed that he did not have the films from September 12, 2007 either. When asked if significant wasting of the chest and upper extremities as noted by Dr. Lange was consistent with a longstanding, chronic, advanced degenerative cervical condition resulting in radiculopathy, Dr. Gornet responded that they did not know how long some of the chest wasting had been there. He testified that he did not dispute Dr. Lange's assumption that this was consistent more with a longstanding issue, but he had seen it occur fairly rapidly in as little as 3-4 months. (PX13).

As it pertains to 05 WC 48261, the medical records of Dr. Kaylea Boutwell were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that on October 27, 2010, Petitioner underwent a C4/5, C6/7 epidural steroid injection. It was noted that the diagnosis was that of bilateral upper extremity radiculopathy. (PX14).

As it pertains to 05 WC 48261, the transcript of the deposition of Dr. David Lange taken on March 29, 2011 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Lange testified that he specializes in orthopedic spine surgery and is board-certified. He testified that he examined Petitioner on November 16, 2010. He testified that he also authored a report dated February 5, 2011 at the request of Respondent's counsel. (RX1).

Dr. Lange testified that the history provided by Petitioner was that as part of his usual activities as a firefighter, he and another individual were in a truck with bad suspension, bottomed out and "shot [them] both into the roof of the cab" meaning that they struck their heads and that he was sore and tingly subsequent to the event. He testified that Petitioner indicated to him that he continued to work his usual full duty job up until approximately November 2004 when he retired due to a cardiac condition. (RX1).

Dr. Lange testified that Petitioner volunteered that he did not seek medical attention for the neck complaints until 2006 and that he indicated that he tried to get in to see Dr. Kennedy in 2006 but that due to some insurance issues, he was unable to do so. He testified that Petitioner reported that he was able to

get in to see Dr. Wright at Washington University Medical School in approximately 2007, that he underwent some testing and that he was led to believe that there was no surgical solution. He testified that Petitioner reported that his symptoms evolved to the point that in 2009, he developed numbness in his shoulder and had difficulty raising the shoulders. He testified that Petitioner indicated to him at the time of the examination that he was significantly disabled in that his existence essentially was chair to bed to chair and that even to do this, it required Vicodin. He testified that Petitioner stated that the worst of the pain was pain in the mid and upper portion of the neck and that he had discomfort that passed into both arms in the lateral arms running down his hands into the radial side of the forearms on both sides. He testified that Petitioner indicated that he simply could not use his shoulders because of the sensation of weakness with attempted either flexing the shoulders or abducting and that when he did so, there was significant discomfort in the shoulders themselves. He testified that Petitioner also indicated that he had difficulties with his hands and that he could not bend the fingers, and that he had significant pain along the volar surface of each wrist. (RX1).

Dr. Lange testified that the examination performed was positive and lamentable, and that Petitioner had significant protraction of the shoulders which was typical with significant atrophy of the musculature in the bilateral arms and also the chest musculature. He testified that Petitioner's reflexes were depressed everywhere but that the Hoffman testing was negative, which meant there was nothing to suggest spinal cord compression. He testified that Petitioner had significant limitation of movement of the neck and complained of his usual mid and upper neck pain with all movements and that there was some peculiar movement of the shoulders on the thorax. He testified that Petitioner could not lift the arms up over a right angle and that it required movement of the entire shoulder girdle on the thorax as opposed to movement at the shoulder itself. He testified that Petitioner had significant atrophy of the arms, that his fingers were swollen, that the hands themselves were puffy and that the hands almost looked like mitts at the end of the extremities. He testified that Petitioner's whole presentation was very unusual. (RX1).

Dr. Lange testified that it was not unreasonable to assume that many of Petitioner's findings were related to the cervical spine and that it would make sense that he would have limitation of movement of the neck and that he might have neck pain with that, but that the rest of the exam was very peculiar and more consistent with some other systemic process. He testified that he reviewed various radiographic studies and that they were of diagnostic quality, and that he also reviewed various medical records that were provided to him. (RX1).

Dr. Lange testified that he did not have an exact diagnosis for Petitioner above and beyond his degenerative disc changes and that he was very sympathetic to Petitioner because of his presentation. He testified that with the paucity of records that were concurrent with the May 5, 2004 incident, it was impossible for him to associate Petitioner's current medical condition with the incident and that there were no medical records dealing with the cervical spine concurrent with the May 5, 2004 incident. He testified that he believed that the first notes were in perhaps 2007 or late 2006, that there was a 2-3 year gap and that he did not think one could logically associate the current symptoms with something that may have occurred on May 5, 2004. (RX1).

Dr. Lange testified that he was sent the transcript of the deposition of Dr. Gornet. He testified that reading it caused him to go back and look in better detail at the Washington University cardiology records and that he felt that the opinions of Dr. Gornet would not change his opinion. (RX1).

On cross examination, Dr. Lange agreed that Petitioner gave the same history of his injury to his neck to Dr. Eavenson, Dr. Wright and Dr. Rotman as was given to him. He agreed that there was a note in the primary care physician records that on August 17, 2007 Petitioner had neck pain, tried to see Dr. Kennedy and was told that Dr. Kennedy would not see the patient unless he had worker's compensation papers. He agreed that his opinion on causation was not based on any type of conflict of history that he

gave to the doctors but simply the fact that there was no record of his complaining until 2006 or 2007 about the neck. (RX1).

On cross examination, Dr. Lange agreed that he found the physical condition of Petitioner on examination to be lamentable. He agreed that the description of Petitioner's upper body was abnormal and that his findings of unusual movement in the scapulothoracic portion of his body was abnormal. He agreed that he did not detect any scapular winging. He agreed that if the source of the unusual movements was in the scapular or the musculoskeletal structures of the scapula, there would be at least some evidence of scapular winging on one side or probably both. He agreed that whatever the source of the unusual movements, it would not be damage to the scapular area of the patient. (RX1).

On cross examination, Dr. Lange testified that the post-myelographic CT disclosed very abnormal findings at multiple levels and was "quite positive." He agreed that the MRI was also quite positive and compatible with the myelogram obtained a little more than two months before it. He testified that he did not have occasion to compare the findings in 2010 with the findings in 2003, but that they would not be lesser findings and that it would be reasonable to assume that they would be worse. He testified that they knew that Petitioner's neck was not normal going back to the 2003 reports, but that he did agree that with such degenerative changes Petitioner would be at risk for developing symptoms including traumatic events. (RX1).

On cross examination, Dr. Lange testified that if there were medical notes that suggested an increase or different symptoms continuing after May 5, 2004, his opinion on causation might change. He agreed that the electrodiagnostic records that he reviewed were positive, and testified that there were bilateral multilevel radicular findings and were quite abnormal. He agreed that he thought that the physical findings as of the November 16, 2010 examination were permanent. He further agreed that based on the findings, he agreed that as far as Petitioner's upper extremities were concerned he could not perform the duties of a firefighter. (RX1).

As it pertains to 05 WC 48261, the medical records of Dr. George Schoedinger were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Petitioner was seen on October 25, 1995, at which time it was noted that he reported a two-year history of soreness about his neck without trauma or other incident. It was noted that over the past six weeks Petitioner had noted a marked increase of his symptoms subsequent to awakening with severe right lateral deltoid pain such that he sought the advice of physicians at the Emergency Room at St. Elizabeth's Medical Center in Granite City, that x-rays were obtained and that Petitioner was advised that he could return home. It was noted that thereafter Petitioner began to note a feeling of numbness and weakness in his right forearm and hand, that his hand symptoms had persisted to the present time and that he later began to note pain about the posterior surface of his right shoulder, radiating into his right arm. It was noted that because of weakness in the right upper limb such that he dropped objects, Petitioner was advised to seek an orthopedic opinion. It was noted that Petitioner reported pain about the posterolateral surface of his neck to the right side of the midline and primarily about the lateral surface of his right deltoid and posterior shoulder, that he noted numbness about the thumb and dorsal surface of his right hand on its radial aspect and that he noted diminished grip on the right side. It was noted that Dr. Schoedinger believed that Petitioner's symptoms and physical findings suggested the presence of a ruptured cervical disc in combination with degenerative cervical disc disease. Petitioner was recommended to undergo an MRI in addition to electrodiagnostic studies. Petitioner was allowed to continue working, was advised to lose weight and was advised to stop smoking. (RX2).

Included within the records of Dr. Schoedinger was an interpretive report for an MRI of the cervical spine performed on November 9, 1995, which was interpreted as revealing (1) broad posterior spur and enlarged annulus C5-C6 resulting in focal anterior extradural defect here with bilateral C5-C6 neuroforamen stenosis. Also included within the records of Dr. Schoedinger was the interpretive report for an EMG performed on November 6, 1995, which was interpreted to be a normal study. (RX2).

The records of Dr. Schoedinger reflect that Petitioner was seen on August 21, 2003, at which time it was noted that his chief complaint was that of neck and upper limb pain. It was noted that Petitioner reported having developed pain in and about his neck while participating in physical therapy during which time he was swimming, that he noted no specific injury and stated that since the onset of discomfort his symptoms had increased in severity such that by June of 2003 his symptoms were sufficiently severe that he stopped engaging in physical therapy. It was noted that Petitioner had a long history of cervical complaints and was seen in the office in 1995, at which time he was found to have evidence of disc pathology at C5-C6 and that his symptoms were treated with non-operative measures including chiropractic manipulation which diminished his symptoms. It was noted that Petitioner stated that his current symptoms seemed to be of the same type noted previously although far more severe than that which he had experienced in the past and that because of persisted difficulty, he presented in the office. It was noted that Petitioner reported posterior neck pain with occasional radiation of pain into the radial surface of his right arm and forearm extending to the level of the wrist, that he noted no sensory loss or motor weakness and that he was left hand dominant. It was noted that x-rays of the cervical spine were obtained in the office on that date which revealed no evidence of fracture, neither recent or old, dislocation, neoplastic disease, congenital anomaly, chronic infection or metabolic disturbance and that degenerative changes were present at multiple levels, most marked at the C5-C6 and C6-C7 levels where disc space narrowing and hypertrophic new bone formation was present in conjunction with foraminal encroachment. Petitioner was recommended to undergo an MRI of the cervical spine. (RX2).

The records of Dr. Schoedinger reflect that Petitioner was seen on August 20, 2003 for cervical spine x-rays, at which time it was noted that he was doing physical therapy in May and felt a pain in his neck. The films were interpreted as revealing degenerative osteoarthrosis changes in the cervical spine with advanced degenerative spondylosis changes C5-6 and to a slightly lesser degree C6-7 compromise both in the C5-6 and C6-7 neuroforaminal on the right secondary to uncovertebral hypertrophy changes. The records reflect that Petitioner underwent an MRI of the cervical spine on August 25, 2003, which was interpreted as revealing (1) multilevel extradural defects, which are most prominent at C4-5, C5-6 and C6-C7; (2) these are accompanied by large soft disc abnormalities; (3) severe compromise of the right neural canal at C6-C7 is evident, along with prominent compromise of the C5-C6 neural canals bilaterally. (RX2).

Included within the records of Dr. Schoedinger was a letter dated August 26, 2003, which indicated that the MRI of the cervical spine had been reviewed and revealed evidence of multilevel degenerative change with posterior disc protrusion extending from C4 to C7. It was noted that Petitioner was told that until such time that he was unable to live with his difficulty, Dr. Schoedinger recommended only non-operative measures. It was noted that Petitioner was uncertain what he wished to do and therefore was to continue with conservative measures alone at that time. It was noted that Petitioner could continue working. (RX2).

As it pertains to 05 WC 48261, the documentation pertaining to Petitioner's prior IWCC claims was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The documentation reflects that case 85 WC 20118 alleged a date of accident of April 5, 1985 and was settled on January 17, 1989 for 53.5% loss of use of the person-as-a-whole. The documentation further reflects that 02 WC 64834 alleged an accident date of October 27, 2002 and was settled on October 14, 2008 for 55% loss of use of the left leg. (RX3).

As it pertains to 05 WC 48261, the 02 WC 64834 Approved Settlement Contract was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

As it pertains to 05 WC 48262, the Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

As it pertains to 05 WC 48262, the medical records of Dr. Rodney Greeling were entered into evidence at the time of arbitration as Petitioner's Exhibit 2.[1]

As it pertains to 05 WC 48262, the medical records of Barnes Jewish Hospital (*i.e.*, November 2, 2004 through November 14, 2006) were entered into evidence at the time of arbitration as Petitioner's Exhibit 3A. The records reflect that Petitioner was seen in the Emergency Department on November 12, 2006 for an admitting diagnosis of shortness of breath and a principal diagnosis of anxiety. The Discharge Instructions noted that Petitioner's principal diagnosis was shortness of breath likely due to anxiety. It was noted that Petitioner had a recent unchanged stress test. The Nursing Assessment dated November 14, 2006 noted that the nursing diagnosis was that of dyspnea and/or shortness of breath related to possible coronary artery insufficiency. The Emergency Department Summary dated November 12, 2006 noted that Petitioner complained of shortness of breath and thought it was not associated with cardiac. It was noted that Petitioner had a stress test a few weeks ago which was negative. The Admission History & Physical noted that Petitioner had a history of coronary artery disease, hypertension and diabetes and that he was admitted with shortness of breath. It was noted that Petitioner stated that for the last several weeks, he had had increasing dyspnea which was not severe until recently, that his symptoms worsened over the last week and that they occurred at rest and were somewhat relieved when lying down. It was noted that Petitioner denied any associated chest pain symptoms and that he felt a "sensation of smothering" which was different than his prior angina symptoms. It was noted that Petitioner was admitted for observation, that his troponins had been negative and that his symptoms had resolved with supplemental oxygenation. It was noted that Petitioner's Past Medical History was positive for (1) coronary artery disease with chronic total occlusion of obtuse marginal branch, successfully revascularized; patient had a stress test performed last month which showed ischemia in that distribution; (2) hypertension; (3) diabetes; (4) reflux. The Assessment and Plan was noted to be that of (1) shortness of breath; patient is dyspneic; there are many possible etiologies which may include ischemia, ischemic MR, underlying lung disease, PE and anxiety, among other issues; he does have known coronary artery disease with a chronic circumflex occlusion; this does not appear to be changed based on his recent stress test; (2) claudication symptoms; patient does have symptoms of claudication, will check AAIs; (3) continue patient's current regimen for his diabetes and his dyslipidemia. (PX3A).

The records of Barnes Jewish Hospital reflect that Petitioner was seen on November 2, 2004 for an admitting diagnosis of chest pain and a principal diagnosis of coronary atherosclerosis of native coronary vessel. Petitioner underwent a left heart cardiac catheterization, coronary anteriography using two catheters and angiocardiography of left heart structures on November 2, 2004. The Pre-Cardiac Catheterization Work-Up noted that Petitioner stated that he had a history of left-sided chest pain with shortness of breath with exertion for two years, that now his symptoms were occurring 4-5 times a day and at rest and that he was also having right shoulder pain which was new. It was noted that Petitioner also reported that last summer while fighting fires his co-workers became concerned about his color and diaphoresis. The Discharge Summary dated November 3, 2004 noted that Petitioner stated that he had been experiencing chest discomfort after fighting fires for years and that over the past month it had occurred across his chest and shortness of breath had been occurring even without fighting fires. It was noted that Petitioner was referred to a cardiologist and had a stress test performed October 13, 2004 with recommendations for cardiac cath lab. It was noted that Petitioner was discharged home on November 3, 2004 with diagnoses of coronary artery disease, status post failed PCI to OM, medical management pursued, hypertension, diabetes and high cholesterol. The Cardiac Catheterization Report dated November 2, 2004 noted that Petitioner underwent cardiac catheterization in 2002, at which time he was noted to have an occluded inferior ramus of a large OM branch, that an attempt was made to reopen the vessel but was unsuccessful and that the left anterior descending and right coronary arteries had mild disease. The diagnostic impressions were noted to be that of (1) normal left ventricular systolic function with a mild distal

[1] The records at issue were included in Petitioner's Exhibit 3 as entered into evidence at the time of arbitration in 05 WC 48261.

posterobasal wall motion abnormality; left ventricular enlargement is present; (2) mild mitral valve prolapse without mitral regurgitation; (3) significant two vessel coronary artery disease with an occluded inferior ramus of the OM branch of the left circumflex and a moderate narrowing of the right coronary artery. (PX3A).

As it pertains to 05 WC 48262, the medical records of Barnes Jewish Hospital (*i.e.*, November 14, 2006 through November 2, 2009) were entered into evidence at the time of arbitration as Petitioner's Exhibit 3B. The records reflect that Petitioner underwent transthoracic echocardiography on October 13, 2009, which was interpreted as revealing upper normal LV mass index, normal systolic function, EF=60%; minimally increased pericardial space with echo-dense material, consider pericardial fat pad vs. thrombus vs. mass; mild LAE; normal RV and RA; normal inferior vena cava. The records reflect that Petitioner underwent chest radiography on November 12, 2006, which was interpreted as revealing no significant interval change; heart size and pulmonary vascularity are normal; a tortuous atherosclerotic aorta is again seen; no focal pneumonic consolidation identified; no pneumothorax or pleural effusion seen; no mediastinal lymphadenopathy noted; some mild degenerative spurring in the lower thoracic spine present. (PX3B).

The records of Barnes Jewish Hospital reflect that on May 27, 2009, Petitioner underwent pharmacologic nuclear stress testing which was interpreted as revealing negative ECG evidence of ischemia after IV Adenosine. The records reflect that Petitioner also underwent myocardial radionuclide imaging on the same date, which was interpreted as revealing (1) small, mild, inferolateral myocardial ischemia; (2) normal left ventricular size and systolic function; (3) since the previous study dated October 16, 2006, both the severity of the ischemia and left ventricular systolic function appear to have improved. The records reflect that on January 22, 2008, Petitioner underwent bone radionuclide imaging for a history of upper neck/occipital pain possibly related to trauma three years ago, and that the study was interpreted as revealing no focal uptake within the upper cervical spine or occipital region to explain the patient's pain. (PX3B).

The records of Barnes Jewish Hospital reflect that on January 3, 2008, Petitioner underwent cervical spine radiography for a history of trauma and neck pain and the imaging was interpreted as revealing degenerative changes of the cervical spine. The records reflect that Petitioner underwent a treadmill nuclear stress test on October 18, 2006, which was interpreted as revealing average exercise performance; equivocally positive ECG evidence of ischemia during exercise stress test, findings are borderline or do not meet strict criteria for a positive test but the changes could be ischemic in origin; the specificity for the study is decreased due to rapid resolution of the abnormalities during recovery. Petitioner also underwent myocardial radionuclide imaging on the same date, which was interpreted as revealing (2) moderate-sized, moderate-severity myocardial ischemia in the inferolateral wall, unchanged since prior study dated October 13, 2004; (2) normal left ventricular size and systolic function. The records reflect that Petitioner underwent myocardial radionuclide imaging on October 13, 2004, which was interpreted as revealing a moderate-sized area of ischemia of moderate severity in the inferolateral wall; there is mild left ventricular enlargement; the left ventricular ejection fraction is normal at 56%. Petitioner also underwent a stress test on that date as well, which was interpreted as revealing positive asymptomatic ECG evidence of ischemia during an exercise stress test; the specificity of the study is decreased due to the rapid resolution of the abnormalities during recovery; exercise capacity is fair. (PX3B).

The records of Barnes Jewish Hospital reflect that on October 6, 2004, Petitioner underwent transthoracic echocardiography, which was interpreted as revealing normal LV and LA size with normal systolic function, abnormal relaxation, normal estimated LVEDP; no regional wall motion abnormalities noted. On November 14, 2006, Petitioner underwent transthoracic echocardiography, which was interpreted as revealing borderline LVH, low-normal systolic function, EF ~ 50%; E/A reversal c/w impaired diastolic function; mild TR. (PX3B).

As it pertains to 05 WC 48262, the medical records of Washington University – Department of Cardiology were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on September 27, 2006, at which time it was noted that since his last visit he was happy to say that he was retired and was doing well. It was noted that Petitioner had noted one episode of chest pain symptoms that occurred in July on a trip to Chicago and that he felt these were more likely due to indigestion. It was noted that Petitioner had had no further symptoms but did state that he was only able to walk two blocks and then had to stop due to pains in both of his knees. It was noted that Petitioner had intermittent chest pain symptoms otherwise. The issues were noted to be that of coronary artery disease; chest pain; hypocholesterolemia; hypertension; and carotid obstructive lung disease. A stress test was ordered and Petitioner was instructed to continue his current cardiac regimen. At the time of the April 4, 2007 visit, it was noted that Petitioner had been last seen during his hospitalization in November 2006 when he had chest pain symptoms. It was noted that Petitioner's evaluation at that time was felt to be remarkable and that they thought he had significant recurrent anxiety as well. It was noted that since that time, Petitioner had undergone GI evaluations. It was noted that Petitioner denied any other symptoms such as significant chest pain or shortness of breath, that he had occasional palpations and that he had chronic circumflex occlusion. The impression was noted to be that of (1) coronary artery disease; (2) chronic circumflex occlusion; (3) hypertension; (4) diabetes; (5) dyslipidemia. Petitioner was instructed to continue his current cardiac regimen. (PX4).

The records of Washington University – Department of Cardiology reflect that Petitioner was seen on October 17, 2007, at which time it was noted that he returned feeling pretty well and denied any significant chest pain symptoms. It was noted that Petitioner denied any problems with orthopnea, PND, syncope, near syncope or palpitations and that he had gained some weight over the summertime after losing about 20 pounds. It was noted that Petitioner stated that it was due to the fact that he had such a bad neck problem. The issues were noted to be that of (1) coronary artery disease with chronic circumflex disease; (2) dyslipidemia; (3) obesity; (4) hypertension; (5) diabetes. It was noted that Petitioner stated that he may require neck surgery and it was noted that he had a stress test done a year ago and had new symptoms and was a low perioperative risk. At the time of the April 23, 2008 visit, it was noted that Petitioner's physical activity was modest due to orthopedic limitations. It was noted that Petitioner had seen Dr. Wright from Spine Service who had given multiple injections and that he had had some pain management overall. It was noted that Petitioner overall felt well from a cardiac perspective. The issues were noted to be that of (1) coronary artery disease with chronic circumflex disease; (2) dyslipidemia; (3) hypertension; (4) physical inactivity. Petitioner was encouraged to be more active if possible. (PX4).

The records of Washington University – Department of Cardiology reflect that Petitioner was seen on October 29, 2008, at which time it was noted that he continued to do well from a cardiac perspective with no significant chest pain symptoms. It was noted that Petitioner stated for the last six months he had taken nitroglycerin 1-2 times but had had no change in his symptoms. It was noted that Petitioner was not particularly active due to neck problems. The issues were noted to be that of (1) coronary artery disease with chronic circumflex occlusion; (2) dyslipidemia; (3) hypertension; (4) chronic neck pain. Petitioner was instructed to continue his current medical regimen. Included within the records of Dr. Kates was a letter dated June 20, 2006 directed to the Granite City Firefighters Pension Board, which noted that Petitioner had been seen an examined twice since the last correspondence dated May 17, 2005. It was noted that Petitioner's condition remained the same (*i.e.*, coronary artery disease with exertional angina) and that it remained his opinion that Petitioner was no longer capable of fighting fires due to this condition and the increased risks associated with firefighting, which may have contributed to this condition, including toxic gases, extreme physical exertion, temperature extremes, stress and danger. (PX4).

The records of Washington University – Department of Cardiology reflect that Petitioner was seen on March 29, 2006, at which time it was noted that he continued to do well from a cardiac standpoint with only intermittent chest pain symptoms. It was noted that Petitioner had had no problems with orthopnea,

PND, no syncope or near syncope. It was noted that Petitioner continued to work out with a trainer for a couple of hours about two times per week and that he did not otherwise exercise. The issues were noted to be that of (1) coronary artery disease with chronic stable angina; (2) dyslipidemia; (3) diabetes; (4) hypertension. Petitioner was recommended to continue his current cardiac regimen. Included within the records was a letter dated September 28, 2005 directed to Chief Tim Connoly, which noted that Petitioner continued to have exertional angina and that Dr. Kates' continued recommendation was that he not participate in firefighting at that time. At the time of the September 28, 2005 visit with Dr. Kates, it was noted that Petitioner continued to have some anginal symptoms prior to sublingual nitroglycerin pills about once every 1½ weeks. It was noted that the symptoms tended to occur with exertion although they had also occurred on bingo nights when there was heavy smoke in the air. It was noted that Petitioner had had no changes in his anginal symptoms over the last several months and that he denied any orthopnea or PND. The issues were noted to be that of (1) coronary artery disease with occluded circumflex; (2) hyperlipidemia; (3) hypertension; (4) diabetes. (PX4).

The records of Washington University – Department of Cardiology reflect that Petitioner was seen on March 9, 2005, at which time it was noted that he continued to have intermittent chest pain symptoms that occurred only on rare occasions, that they lasted for about 30 seconds and that he did not require any nitroglycerin. It was noted that Petitioner had not been that active over the winter due to the cold but was looking forward to exercising again. The impression was noted to be that of (1) coronary artery disease; (2) hyperlipidemia; (3) hypertension; (4) diabetes. Included within the records was a letter dated March 22, 2005, which noted that Dr. Kates continued with his recommendation that Petitioner not participate in firefighting at that time. It was noted that it was likely that Petitioner would be unable to return to firefighting and that he would be reassessed on September 7, 2005. Another letter dated March 9, 2005 directed to the Granite City Pension Fund noted that Petitioner had stable anginal symptoms and that he had had significant anginal symptoms in the setting of significant exertion, especially while conducting his job fighting fires. It was noted that it was Dr. Kates' feeling that Petitioner had significant anginal symptoms that prevented him from conducting his job and that he had significant coronary artery disease. (PX4).

The records of Washington University – Department of Cardiology reflect that Petitioner was seen on December 1, 2004, at which time it was noted that following his last visit, he underwent coronary angiography which demonstrated chronic OM occlusion. It was noted that attempted angioplasty of the vessel was unsuccessful and that Petitioner was therefore treated medically. It was noted that at Dr. Kates' urging, Petitioner had stopped his work as a firefighter. The assessment was noted to be that of (1) coronary artery disease; (2) dyslipidemia; (3) occupation, with Dr. Kates noting that it was his recommendation that Petitioner not work as a firefighter in view of his significant coronary artery disease as a potential risk to himself as well as others. Included within the records was a letter dated December 1, 2004 directed to the Granite City Pension Fund, which noted that Petitioner had anginal symptoms as a result of his coronary artery disease and that he stated to Dr. Kates on several occasions that he had anginal symptoms with any significant exertion and specifically while conducting his job in fighting fires. It was noted that it was Dr. Kates' opinion that Petitioner had significant anginal symptoms that prevented him from conducting his job and that the physical and emotional stress associated with firefighting would be unsafe in view of his significant coronary artery disease. At the time of the November 2, 2004 visit, it was noted that Petitioner's diagnostic catheterization demonstrated a chronically occluded obtuse marginal branch with evidence of collateralization, that there was a 40% LAD and a 50% distal RCA lesion and that his LV function was normal with mild ventricular prolapse but no mitral regurgitation. It was noted that Petitioner had significant anginal symptoms which he described as occurring with any significant exertion including fighting fires and that Petitioner had been recommended to not participate in firefighting until which time his anginal symptoms were controlled or he no longer had demonstrable ischemia. (PX4).

The records of Washington University – Department of Cardiology reflect that Petitioner was seen on September 22, 2004, at which time it was noted that he had known chronic obtuse marginal lesion which was diagnosed approximately two years ago and that he stated that he recently completed 14 months of rehab for his left problems and during that time experienced significant weight gain and "digestive problems." It was noted that over the last few months Petitioner had noted increasing shortness of breath and chest pain with exertion, that it occurred about 3-4 times per day and that it lasted for 5-10 minutes. It was noted that Petitioner stated that the chest pain symptoms had been somewhat improved on stopping glyburide and that the chest pain symptoms were more indigestion than true chest pain. It was noted that the shortness of breath was still similar to his anginal symptoms that he had at the time of his diagnosis of coronary artery two years ago. It was noted that Petitioner noted that his symptoms seemed to be a lot worse with anxiety and stress and that he had quite an amount of stress lately and that he was a fire captain and was under a fair amount of stress lately. It was also noted that Petitioner stated that his symptoms seemed to be worse when he was fighting fires. The Past Medical History was noted to include (1) coronary artery disease; left heart catheterization in October 2002 demonstrated normal LV function with subtotal first obtuse marginal lesion; no significant MR; he underwent attempted angioplasty of two vessels, which was unsuccessful; (2) hypertension; (3) diabetes; (4) status post left knee surgery; (5) chronic back pain. It was noted that Petitioner presented with anginal symptoms. Petitioner was recommended to undergo a stress test to exclude significant ischemia as well as an echocardiogram to evaluate his left ventricular function and for valve disease. (PX4).

The records of Washington University – Department of Cardiology reflect that Dr. Kates authored a letter dated October 27, 2005 to the Granite City Firefighters Pension Fund, which noted that Petitioner had a history of coronary artery disease and had undergone two previous cardiac catheterization procedures and had severe narrowing in one of his coronary arteries. It was noted that attempts were made to open the artery using angioplasty and stent and that it was unsuccessful, and that Petitioner had continued to experience exertional chest discomfort symptoms in a predictable pattern, such as hill climbing and strenuous activity. It was noted that Petitioner had undergone stress testing through Barnes Hospital, which had demonstrated not only the symptoms of chest discomfort but objective findings of poor perfusion to the myocardium of the left ventricle based on a nuclear examination. The impression was noted to be that of (1) coronary artery disease with chronic occlusion of a branch of the circumflex coronary artery with both symptoms and objective findings consistent with ongoing ischemia and exercise limitation; (2) hypertension; (3) diabetes; (4) history of orthopedic surgeries and injuries in the past. It was noted that Dr. Camp was of the opinion that Petitioner's condition precluded firefighting and that it was his opinion that Petitioner's firefighting work over the years had been a contributing condition to his current cardiac impairment. (PX4).

The records of Washington University – Department of Cardiology reflect that Petitioner was seen on May 20, 2009, at which time it was noted that he presented for follow-up after a recent admission to St. Louis University Hospital. It was noted that it was felt at that time that Petitioner may have some issues with asthma and was referred to a pulmonary colleague but that he had not yet been seen by the pulmonary service. It was noted that Petitioner stated that he had an echocardiogram performed at SLU that was "okay" and that his left atrial function was apparently normal at that time. It was noted that on presentation Petitioner was somewhat short of breath with no chest pain complaints and that he had taken nitroglycerin for his shortness of breath but there was no change in his symptoms. The issue was noted to be that of exertional dyspnea and it was noted that it was not clear that he had asthma but was concerned that he may have reflux-induced asthma. Petitioner was recommended to undergo pulmonary function tests and that they had been performed back in 2006 which showed a mild obstructive disease. Petitioner was also recommended to have an adenosine thallium study performed to evaluate for any change in ischemia. The records reflect that Petitioner underwent pharmacologic nuclear stress testing on May 29, 2009, which was interpreted as revealing (1) small, mild, inferolateral myocardial ischemia; (2) normal left ventricular size and systolic function; (3) since the previous study dated October 16, 2006, both the severity of ischemia

and left ventricular systolic function appear to have improved. The records further reflect that Petitioner underwent pulmonary function testing on May 29, 2009, which was interpreted as revealing a mild obstructive ventilatory defect; no clear and significant improvement after the administration of aerosolized bronchodilator; overweight status may be the cause of the decreased ERV; no impairment of gas exchange by DLCO. (PX4).

Included within the records of Washington University – Department of Cardiology was an interpretive report dated October 30, 2009, at which time Petitioner underwent cardiac MRI which was interpreted as revealing (1) no pericardial mass; exuberant pericardial fat likely corresponds to echogenic material within the pericardial space seen on echocardiogram; (2) small pericardial effusion without tamponade physiology. (PX4).

As it pertains to 05 WC 48262, the medical records of Dr. Andrew Kates (*i.e.*, November 2, 2004 through November 5, 2009) were entered into evidence at the time of arbitration as Petitioner's Exhibit 5A. The records reflect that on May 27, 2009, Petitioner underwent a pharmacologic nuclear stress test, which was interpreted as revealing negative ECG evidence of ischemia after IV Adenosine. The records reflect that on November 13, 2006, Petitioner underwent pulmonary function testing, which was interpreted as revealing a mild obstructive ventilator defect; no clear and significant improvement after the administration of aerosolized bronchodilator; no impairment of gas exchange at rest by ABG; no impairment of gas exchange by DLCO; the COHb level is consistent with current non-smoking status. Included within the records was a note dated May 8, 2009 from Dr. Schiller at Saint Louis University, which indicated that Petitioner recently had an inpatient stay on the Cardiology Service and presented with an episode of dyspnea which was slightly increased from baseline. It was noted that Petitioner's symptoms improved spontaneously and that there was noted to be a strong anxiety component as well as some component of reflux. It was noted that Petitioner was doing well on the day of discharge and was discharged home in stable condition, and that he had transthoracic echocardiogram during the admission which showed an LV ejection fraction of approximately 55% but had no significant valvular pathology. (PX5A).

The records of Dr. Kates reflect that Petitioner was seen on April 23, 2008, at which time it was noted that he had done well from a cardiac perspective with no new chest pain symptoms. It was noted that Petitioner's physical activity was modest due to orthopedic limitations and that he had seen Dr. Wright from Spine Service who had given multiple injections. It was noted that there was occasional twinge in the chest and the back but that his twinge symptoms lasted for only 15-30 seconds. The issues were noted to be that of (1) coronary artery disease with chronic circumflex disease; (2) dyslipidemia; (3) hypertension; (4) physical inactivity. (PX5A).

As it pertains to 05 WC 48262, the medical records of Dr. Andrew Kates (*i.e.*, August 2, 2010 through May 15, 2012) were entered into evidence at the time of arbitration as Petitioner's Exhibit 5B.

As it pertains to 05 WC 48262, the report of Dr. Andrew Kates was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The letter was directed to the Granite City Pension Fund and noted that data showed occupational exposures faced by firefighters increased the risk of developing atherosclerotic plaques or precipitated heart attack in firefighters with underlying atherosclerotic heart disease. It was noted that Petitioner reported that his duties as a firefighter were beyond that of average firefighters and that he stated he was often the first responder and fought fires alone for years. It was noted that as a captain, Petitioner stated that he was required to stay at the site until the probable cause of the fire was found, prolonging his exposures, and that it was Dr. Kates' opinion that these factors had contributed to his coronary artery disease and anginal symptoms. It was also noted that it was Dr. Kates' opinion that Petitioner had significant anginal symptoms and coronary artery disease that prevented him from conducting his job. (PX6).

As it pertains to 05 WC 48262, the transcript of the deposition of Dr. Andrew Kates taken on January 19, 2010 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Dr. Kates testified that he is a board-certified cardiologist and is an Associate Professor of Medicine at Washington University School of Medicine. (PX7).

Dr. Kates testified that on September 22, 2004, he saw Petitioner for the first time and that he had been diagnosed with coronary artery disease two years prior to his first meeting him. He testified that Petitioner stated that he had increasing shortness of breath and chest pain over the few months prior to his seeing him and that he was seeking another opinion for his symptoms. He testified that Petitioner stated that his symptoms were worse with anxiety and stress and that he was under quite a bit of stress at that time. He testified that Petitioner stated that he was a fire captain in Granite City and that he said that his symptoms seemed to be worse when he was fighting fires. He testified that Petitioner stated that he had undergone a heart catheterization in October of 2002, that he had high blood pressure and diabetes, that he had had left knee surgery and that he had chronic back pain. He testified that Petitioner indicated that he smoked but had quit ten years before he had seen him and that he used nicotine gum on occasion. He testified that his impression was that Petitioner presented with anginal symptoms and that he had chest pain that may or may not be related to his coronary disease. He testified that he thought that the most appropriate evaluation was a stress test for significant ischemia and should Petitioner have ischemia, then he should undergo further evaluation with angiography. He testified that he also recommended that Petitioner undergo an echocardiogram to evaluate for his left ventricular function and for valve disease. He testified that he did not take Petitioner off work at that time. (PX7).

Dr. Kates testified that Petitioner had a stress test performed that showed lateral ischemia and that he underwent cardiac catheterization at his direction. He testified that he did not personally perform the catheterization but did review the films and that it showed that Petitioner had chronic obtuse marginal occlusion, that he had evidence of collateralization from the distal part of the vessel to the OM and that he had a 50% blockage in his right coronary artery. He testified that the echocardiogram that was performed showed that Petitioner's heart function was normal and that he had no valvular abnormalities. He testified that it was his impression that Petitioner was having symptoms related to the occlusion and that it was reasonable to attempt to revascularize the vessel via performance of balloon angioplasty and stenting. He testified that Dr. Lasala attempted the balloon percutaneous angioplasty on November 2, 2004, but that it was not successful. He testified that following this procedure, they decided to treat Petitioner with medications. He testified that Petitioner indicated to him that he had chest anginal symptoms while fighting fires and that he told him that he should not fight fires if he was having symptoms or until they were adequately controlled. He testified that he did not have notes to the effect that Petitioner was not working in 2004. (PX7).

Dr. Kates testified that he next saw Petitioner in March of 2005, at which time he indicated that he continued to have chest pain symptoms that would last for about 30 seconds and that he did not take any nitroglycerin for it. He testified that Petitioner indicated that he had not been all that active due to the cold but that he was hoping to exercise again. He testified that it was his opinion that Petitioner needed to get his diabetes under better control in the hopes that it would help control his triglycerides. He testified that he authored a letter dated December 1, 2004 to the Granite City Pension Fund in which he indicated that it was his opinion that Petitioner had significant anginal symptoms that prevented him from conducting his job and that the physical and emotional stress of firefighting would be unsafe in view of his coronary artery disease. He testified that he held the same opinion as of the day of the deposition. (PX7).

Dr. Kates testified that his records reflected that he also saw Petitioner in December of 2004 following his heart catheterization and that he was still having chest pain symptoms. He testified that when he saw Petitioner in September of 2005, he stated that he continued to have some anginal symptoms and was taking nitroglycerin pills about once every week and that it primarily occurred with exertion. He testified that he authored a letter dated May 17, 2005 to the Granite City Pension Fund in which he indicated

that Petitioner reported that his duties as a firefighter were beyond that of average firefighters, that he stated that he often was the first responder and fought fires alone for years, that as a captain he was required to stay at the site until the probable cause of the fire was found, prolonging his exposure, and that it was his opinion that these factors had contributed to Petitioner's coronary artery disease and anginal symptoms. He testified that he further indicated that it was his opinion that Petitioner had significant anginal symptoms and coronary artery disease that prevented him from conducting his job. He testified that he continued to hold that opinion. (PX7).

Dr. Kates testified that at no time during his treatment of Petitioner had he recommended any type of heart surgery as he did not think it was indicated. He testified that he had treated Petitioner through medications and risk factor modification. He testified that in his letter to Dr. Greeling in May of 2009, he indicated that Petitioner came to see him after follow-up after he had been admitted to St. Louis Hospital. He testified that the history that he obtained was that Petitioner felt that he may have had some issues with asthma and was referred to the pulmonary service at Washington University. He testified that Petitioner had an echocardiogram performed at St. Louis University. He testified that on the day that he saw Petitioner, he stated that he was a little bit short of breath but had no chest pain complaints. He testified that he asked Petitioner to have pulmonary function testing performed, to undergo a six-minute walk and to have a stress test to look for evidence of any changes in ischemia. He testified that he has not indicated any need for any type of bypass surgery. (PX7).

Dr. Kates testified that he planned on continuing to treat Petitioner and that his plan would be to continue the medical regimen that he was on with appropriate anti-hypertensive therapy, cholesterol-lowering therapy and other risk factor lifestyle changes. He testified that he believed that Petitioner could do other types of less strenuous work. He testified that he believed that he believed that Petitioner's inability to return to firefighting duties was permanent. (PX7).

On cross examination, Dr. Kates testified that to his knowledge Petitioner had not had a myocardial infarction. He testified that Petitioner's risk factors for coronary disease included diabetes, hypertension, a history of tobacco use and a family history of premature coronary artery disease. He testified that obesity was a risk factor and that Petitioner would at least be overweight but that he would have to calculate his BMI to see if he would classify as obese. He also testified that Petitioner had dyslipidemia. He testified that these were significant risk factors for an individual to develop coronary artery disease. (PX7).

On cross examination when asked if the medical literature listed fighting fires as a risk factor for the development of coronary artery disease, Dr. Kates responded that firefighting was not included as one of the traditional risk factors. (PX7).

On cross examination, Dr. Kates agreed that when he began treating Petitioner on September 22, 2004, he reported to him at that time a significant weight gain as a result of being off work and rehabbing 14 months for an unrelated knee condition. When asked if the weight gain contributed to the progression of Petitioner's coronary disease, Dr. Kates responded that the weight gain may well have contributed to a worsening of his symptoms but that he could not state with surety if weight gain over that time period would have specifically caused progression of his coronary disease. He testified that it was possible that a lack of exercise may have an effect on coronary artery disease. (PX7).

On cross examination, Dr. Kates testified that at the time that he first met Petitioner he reviewed the report of a previous heart catheterization from October of 2002, which indicated that he had a subtotal occlusion of the obtuse marginal branch. He testified that Petitioner's coronary artery disease certainly existed as of that date. He testified that Petitioner would have had coronary artery disease prior to the 2004 cardiac catheterization and that it could be a progressive process but did not have to be. (PX7).

On cross examination, Dr. Kates testified that male gender could be a risk factor for coronary artery disease. He testified that advancing age was also a risk factor. He testified that men tended to develop coronary artery disease at a younger age than women did and that physical inactivity was a risk factor for heart disease. (PX7).

On cross examination, Dr. Kates testified that he did not know how long Petitioner was involved in fighting fires. He testified that the length of time Petitioner was involved with actually fighting fires would have an impact in terms of his opinion regarding the relationship between Petitioner's coronary artery disease and those activities and that the longer the exposure, part of his job may potentially worsen his coronary disease. He testified that there was with medical certainty a relationship between Petitioner's work as a firefighter and his coronary artery disease and that there was data that supported a relationship between exposure and stress of firefighters and coronary artery disease. He testified that he did not know if there was a length of time that they had to be engaged in those work activities to have any impact. He admitted that he did not have the references at his fingertips as of the time of the deposition. (PX7).

On cross examination, Dr. Kates admitted that he did not recall whether the studies discussed the length of time an individual would be engaged in the occupation of a firefighter thereby resulting in the development of or acceleration of coronary artery disease. He testified that he did not recall whether or not the studies discussed in any fashion the relationship between firefighting and the development or acceleration of coronary artery disease and the type of safety equipment used by the firefighters. He testified that he last reviewed the data in 2005 and that the purpose of his review of the data at that time was for the letter that he dictated to the Granite City Pension Fund. He testified that he did not recall where he secured the data. He testified that Petitioner asked him to write to the Pension Board and that as part of that, he reviewed the literature before writing the letter. He denied having reviewed any other literature since that time. (PX7).

On cross examination, Dr. Kates agreed that he relied on the history from Petitioner that his job activities as a firefighter involved greater stress as a first-arriver and a more difficult work environment than the other firefighters on the force. He agreed that the history that he relied on from Petitioner resulted in the opinions set forth in the letters he authored. He agreed that his opinion that Petitioner should no longer engage in firefighter activities was as result of the fact that Petitioner had and suffered from rather significant underlying coronary artery disease. (PX7).

On cross examination, Dr. Kates testified that he was not aware of Petitioner's education, background, training or experience. He agreed that Petitioner could be substantially gainfully employed as long as he was not involved with any type of heavy physical exertional activities. He testified that he did not know if Petitioner had engaged in any other substantial gainful employment beyond that of a firefighter for the City of Granite City. He agreed that his current treatment regimen was to address Petitioner's coronary artery disease and his other conditions which were accepted medically as risk factors for that condition. (PX7).

On cross examination when asked to explain the history from the Admission sheet for the November 2, 2004 cardiac catheterization which stated that Petitioner reported back pain as well as emotional stress over the election results that caused his chest pain, Dr. Kates responded that Petitioner reported having some chest pain overnight but that it was associated with emotional stress following the election results. He agreed that as of either November 2 or 3 of 2004, he restricted Petitioner from returning to work as a firefighter. (PX7).

On redirect, Dr. Kates testified that the concern was that following Petitioner's heart catheterization he developed back pain and that one of the potential complications of heart catheterization could be aortic dissection, and that Petitioner was admitted overnight to be watched following the development of back pain. He testified that there was a medical reason for the admission, not an emotional reason. Dr. Kates

testified that Petitioner's risk factor of smoking would have been reduced following cessation of tobacco use. He testified that the risk went down significantly following one year of quitting and that it went down more with each year that Petitioner was off cigarettes to the point that when one was 10 years out from quitting, the risk returned to that of one who had never smoked. He testified that occupational history, even though not a traditional risk factor, was relevant to his treatment of patients. (PX7).

As it pertains to 05 WC 48262, the medical records of Pulmonary Care of Eastern Missouri were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on July 20, 2009, at which time it was noted that he complained of shortness of breath worse over the past seven years but especially worse over the past three months. It was noted that Petitioner had had cardiac and pulmonary evaluation recently that had been fairly unremarkable and that he reported that previously he was a fireman. It was noted that Petitioner injured his leg, that he underwent surgery for his leg and since that time his activity level had decreased significantly. It was noted that Petitioner reported that after initiating Actos for diabetes management and the combination of that along with decreased activity over the past seven years, he had had a 70-pound weight gain. It was noted that Petitioner described his dyspnea as two components, *i.e.*, difficulty getting a full deep breath at times when he was resting and dyspnea on exertion. It was noted that Petitioner had dyspnea going less duration recently and that he also had some nasal congestion. It was noted that Petitioner had been sleeping in a reclining chair for the past ten years and reported some fatigue and tiredness. The impression was noted to be that of (1) dyspnea; (2) neck pain; (3) weight gain; (4) coronary artery disease, which appears to be fairly stable. Petitioner was recommended to undergo a spiral chest CT to rule out pulmonary embolus, to undergo a hypersensitivity pneumonitis panel given his allergic symptoms, to undergo an allergy consultation and to consider a sleep study. It was noted that if the testing was unremarkable, Dr. Paranjothi suspected that it was most likely due to deconditioning. (PX9).

As it pertains to 05 WC 48262, the medical records of St. Louis University Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 10.[2] The records reflect that Petitioner was seen in the Emergency Department on April 29, 2009, at which time it was noted that he reported that since 10:30 that morning he had been having shortness of breath after climbing five flights of stairs. It was noted that Petitioner reported having shortness of breath on and off for about two months. Petitioner was discharged on April 30, 2009 with instructions to follow-up with his cardiologist. (PX10).

As it pertains to 05 WC 48262, the medical records of St. Louis Allergy Consultants were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that Petitioner was seen on July 22, 2009, at which time an Allergy Survey Sheet was completed. The physical examination was noted to reveal a slightly overweight, middle-aged white male in no acute distress, that the chest was clear and that the skin tests were negative. The impression was noted to be that of probable congestive heart failure; symptoms may be aggravated by beta blockers and/or Actos; no allergic basis for complaints; no history compatible with C-1 esterase inhibitor deficiency. Petitioner was recommended to complete an evaluation through Dr. Paranjothi then discuss changing or discontinuing those two drugs with the endocrinologist and with the cardiologist and if no cooperation, consider a second opinion. (PX14).

As it pertains to 05 WC 48262, an Excerpt from the deposition of Dr. Lange was entered into evidence at the time of arbitration as Petitioner's Exhibit 16.[3]

The transcript of the deposition of Dr. Stephen Schuman taken on December 20, 2010 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Schuman testified that he specializes in internal medicine and cardiology and is board-certified in both. (RX1).

---

[2] Any highlighting that appears in the exhibit was not made by the Arbitrator.

[3] The transcript in its entirety was entered into evidence as Respondent's Exhibit 1 in 05 WC 48261.

Dr. Schuman testified that he examined Petitioner on January 23, 2008 and that the history given to him was that he was a 57-year-old former firefighter and captain for Granite City and that he noticed beginning in April of 2004 substernal chest pain with shortness of breath after fighting a fire. He testified that Petitioner reported that sometimes he would get it during the fire but ignored it and kept working and that he noticed it after finishing and took about 15 minutes for it to subside. He testified that Petitioner reported that this would occur with any kind of work, whether fighting a fire or going to the scene of a car accident, etc. and that he did not describe it as occurring outside of work. He testified that Petitioner reported that by June of 2004, his chest pain was lasting 30 minutes before subsiding. He testified that on or about October 5, 2004, the steel mill in Granite City was on fire, that Petitioner was inside, that he had all of his gear on and that after fighting that fire, Petitioner could not catch his breath for about 30 minutes. He testified that Petitioner indicated that his battalion chief and driver wanted him to go to the hospital but he did not, and that he saw his personal physician after that. He testified that his primary care physician sent him to Dr. Kates at Barnes, who did a cardiac catheterization and then told him that he had to retire from firefighting. (RX1).

Dr. Schuman testified that it was his opinion that Petitioner did not suffer a myocardial infarction. He testified that his diagnosis was that of underlying atherosclerotic coronary artery disease and that he had angina pectoris. He testified that Petitioner had several factors that would cause the development of atherosclerotic heart disease, including type II diabetes, cigarette smoking, hypertension, dyslipidemia, male gender and advancing age. He testified that he did not believe that there was any relationship between the atherosclerotic heart disease and Petitioner's work activities as a firefighter. (RX1).

Dr. Schuman testified that he was provided some additional medical records which resulted in his preparing a report dated January 4, 2010 and that none of the records he was provided altered his opinion. He testified that he also had opportunity to read the transcript of the deposition of Dr. Kates and that this resulted in his preparing a report of February 12, 2010. He testified that he and Dr. Kates agreed on may fundamental issues including Petitioner's symptoms. He testified that Petitioner apparently exerted more at work than he did at home, so to him it was not surprising that most of his chest pain episodes occurred during exertion or fighting fires. He testified that if at home or in an exercise program Petitioner did exertion to the level of fighting a fire, he would have gotten anginal chest pain there as well. He testified that he and Dr. Kates agreed that Petitioner had several risk factors, such as the hyperlipidemia, diabetes, hypertension and advancing age. (RX1).

Dr. Schuman testified that he agreed with part of Dr. Kates' opinions regarding what caused Petitioner's shortness of breath. He testified that it was possible that some of the shortness of breath on exertion was due to diastolic or relaxation dysfunction. He testified that Petitioner had normal left ventricular systolic or pumping function and that he had impaired relaxation or diastolic dysfunction, which was due to a hypertension and not coronary artery disease. He testified that it was possible that some of Petitioner's dyspnea was due to the diastolic dysfunction and that resulting pulmonary congestion on exertion was causing shortness of breath. He testified that the bottom line was that Dr. Kates testified that there was a relationship between Petitioner's firefighting and his coronary artery disease and that he was not listing any references, but that he was not aware of any that were in actual study that "teased out" all of the other risk factors. (RX1).

Dr. Schuman testified that he did not concur with Dr. Kates' opinion that there was a relationship between firefighting and Petitioner's coronary artery disease. He testified that he thought that Petitioner had five or six other risk factors that would explain his coronary artery disease. He testified that he agreed that based on Petitioner's underlying atherosclerotic heart disease, he could discontinue his employment as a firefighter and that he also agreed with Dr. Kates that there was no indication in any of the medical records that Petitioner suffered a myocardial infarction. (RX1).

On cross examination, Dr. Schuman agreed that he had seen Petitioner on one occasion on January 23, 2008. He testified that he spent one hour for the history and physical. He testified that he was not familiar with Dr. Kates and that he had no opinion about his professional reputation in the St. Louis community. (RX1).

On cross examination, Dr. Schuman agreed that in his report of January 31, 2008, Petitioner described a series of exertions at work that made him symptomatic but that he did not have those at home. He agreed that if during these work exertions Petitioner would have actually suffered an infarction, his opinion would be that the exertional activities were in part a cause of the infarction. He agreed that his testimony was that Petitioner did not have an infarction and that the exertional activities caused the symptoms of chest pain but not any damage to heart tissue. He agreed that in each of these instances, Petitioner returned to exactly the same physical condition he was in before the episode of angina. He disagreed that each of the exertional activities actually accelerated the episode of angina. He testified that he did not see how anyone could say that there was a relationship between the exertional symptoms and a progression of the underlying coronary atherosclerosis. He testified that there was a pathophysiology that was simply conjecture since Petitioner did not go to the hospital to see whether or not it occurred. (RX1).

On cross examination, Dr. Schuman agreed that the symptoms were a response to the receptors in Petitioner's body that something abnormal was going on inside the chambers of the heart and that that was why he was feeling pain and fatigue. He testified that a patient would experience the ischemia or the supply/demand imbalance as pain, heaviness or tightness in the chest and that it could be associated with shortness of breath. He testified that when the heart slowed down and the supply and demand balance subsided, the pain subsided and there was no permanent damage and that the person was back to the way they were just before the event occurred. He testified that repeated angina was not a myocardial infarction. (RX1).

On cross examination, Dr. Schuman agreed that the duration and amount of tobacco use altered the risk factor, meaning that someone who smoked more heavily was at greater risk than someone who smoked less heavily. He agreed that someone who smoked less than a pack a day had less of a risk factor than one who smoked two packs a day. (RX1).

Petitioner's Work Schedules 1999-2004 were entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The Printout of Petitioner's prior IWCC Claims was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The documentation was duplicative of that as contained in Respondent's Exhibit 3 as contained in 05 WC 48261. (RX3).

The medical records of Cardiology Specialists were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records reflect that Petitioner underwent dual isotope stress testing on August 9, 2002, which was interpreted as revealing (1) maximal exercise stress test that is negative for ischemia; (2) no exercise associated chest discomfort; (3) hypertensive blood pressure response to exercise; (4) no exercise associated arrhythmias; (5) diminished functional capacity; (6) nuclear medicine results to be reported separately. The Gated Spect Dual Isotope Perfusion Study with Wall Motion Ejection Fracture also performed on August 9, 2002 was interpreted as revealing mild ischemia along the infero-lateral wall; no infarct; mild hypokinesia along the lower septum; ejection fraction is 56%. (RX4).

The records of Cardiology Specialists reflect that Petitioner underwent chest x-rays at Anderson Hospital on July 29, 2002 for an indication of shortness of breath, dyspnea on exertion and that the films were interpreted as revealing cardiomegaly; no actively pulmonary disease. A letter dated September 24, 2002 from Dr. Speidel to Dr. Greeling noted that Petitioner underwent cardiac catheterization on that date, that the study was compatible with his stress test and that he had a subtotal occlusion of his obtuse marginal.

It was noted that Petitioner was recommended medical therapy as the lesion could not be crossed. Also included within the records was a letter dated August 20, 2004 from Dr. Speidel to Dr. Greeling, in which it was indicated that Petitioner was scheduled to undergo stress testing on that date and that he came to the office and was somewhat loud and abusive to the staff. It was noted that Petitioner had stormed out of the office and said that he was not going to return and that the office staff was somewhat alarmed by his behavior. It was noted that Dr. Speidel was no longer involved in Petitioner's care. (RX4).

CONCLUSIONS OF LAW

The Arbitrator notes at the outset that 05 WC 48261 was heard on an immediate hearing basis pursuant to a timely-filed 19(b) Petition, while 05 WC 48262 was tried on all issues on June 27, 2017 in Collinsville.

As to 05 WC 48261, with respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident.

Having considered and reviewed the entirety of the medical evidence in this case, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of May 5, 2004. In support of such conclusion, the Arbitrator finds the opinions of Dr. Lange to be more persuasive than those proffered by Dr. Gornet.

The Arbitrator finds to be significant that after the May 5, 2004 incident, the first documented treatment to the cervical spine and report of neck pain occurred on December 8, 2006 in Dr. Greeling's records. (PX3). The Arbitrator finds Petitioner's assertion that he reported neck pain to Dr. Greeling in 2004, 2005 and 2006 to be unsupported by the medical records. Furthermore, the Arbitrator notes that even in the December 8, 2006 note, there was no reference that Petitioner related his neck pain to the work accident at issue. (PX3).

The Arbitrator does not find to be persuasive Dr. Gornet's assertion that the anginal symptoms Petitioner experienced from his heart condition were also likely coming from the cervical spine. (PX13). The Arbitrator notes that Dr. Greeling documented neck pain both before and after 2004, and further finds it to be highly likely that Dr. Greeling would have specifically documented the neck pain if it were, in fact, reported during the timeframe of May 5, 2004 through December 8, 2006.

Given the extensive lack of any documented complaints of neck pain and/or treatment for the neck between the date of accident of May 5, 2004 and December 8, 2006, the Arbitrator finds that there is insufficient evidence to support the finding that the work accident of May 5, 2004 caused any kind of aggravation or exacerbation of Petitioner's pre-existing neck condition so as to make the accident at issue a cause in the need for treatment. As such, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident. As the Arbitrator finds that Petitioner failed to prove that his current condition of ill-being is causally related to his accident of May 5, 2004, all benefits are denied, including the prospective medical treatment requested by Petitioner. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

As to 05 WC 48262, with respect to disputed issue (O) pertaining to the admissibility of various exhibits proffered by Petitioner – specifically, Petitioner's Exhibits 8, 11, 12, 13 & 15 - the Arbitrator notes that Respondent objected to the admission of the reports prepared by Dr. Camp (*i.e.*, PX8), Dr. King (*i.e.*, PX11), Dr. Berarducci (*i.e.*, PX12) and Dr. Ruwith (*i.e.*, PX13) on the grounds of hearsay, and that Respondent further objected to the Final Administrative Decision of the Granite City Fire Pension Board

of Trustees Pension Board (*i.e.*, PX15) as collateral to the proceedings at issue and the fact that Respondent was not a party to such proceedings.

When it comes to treating physicians, statements describing medical history, past or present symptoms, pain, or sensations are admissible as an exception to the hearsay rule if made to the physician for purposes of medical diagnosis or treatment. When it comes to examining physicians, however, evidence of such statements are not admissible under the hearsay exception if made to the physician for the purpose of testifying. *Roszak v. Kankakee Firefighters' Pension Bd.*, 376 Ill. App. 3d 130, 143–44, 875 N.E.2d 1280, 1290–91 (3d Dist. 2007).

In the case at hand, the Arbitrator finds that Drs. Camp, King, Beraducci and Ruwitch were all examining physicians and that their respective reports were prepared solely for the purpose of litigation before the Pension Board. The Arbitrator notes that the reports were all addressed to the Secretary for the Pension Fund and that all of the reports answered questions requested by the Pension Fund. The Arbitrator notes that Respondent was not a party before the Pension Board proceedings and therefore did not have an opportunity to cross-examine the various physicians. As a result thereof, the Arbitrator finds that the reports of Dr. Camp, King, Beraducci and Ruwitch as contained in Petitioner Exhibits 8, 11, 12, and 13, respectively, are all hearsay and that no hearsay exception applies that would allow the reports to be admitted into evidence. The Arbitrator further finds that the Final Administrative Decision of the Granite City Fire Pension Board of Trustees Pension Board as contained in Petitioner's Exhibit 15 is collateral to the proceedings at issue and that given that Respondent was not a party to such proceedings, the Arbitrator disregards the Decision in its entirety. As a result thereof, the Arbitrator does not admit the various reports into evidence and does not consider the various reports when rendering the decision in this matter.

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 November 2, 2004, 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 to be more persuasive the opinions offered by Dr. Schuman as opposed to those offered by Dr. Kates. The Arbitrator notes that the medical evidence reflects that Petitioner had several risk factors for coronary artery disease including his weight, diabetes, hypertension, hyperlipidemia and elevated cholesterol. In fact, Dr. Schuman testified that he and Dr. Kates agreed that Petitioner had several risk factors, such as hyperlipidemia, diabetes, hypertension and advancing age. (RX1). The Arbitrator further notes that both Dr. Kates and Dr. Schuman opined that these risk factors independent of being a firefighter could cause coronary artery disease. (PX7; RX1).

Furthermore, the Arbitrator finds to be significant in this case that Dr. Kates testified that he based his opinion on studies that supported that the hazards and exposures as a firefighter contributed to coronary artery disease, and yet he could not reference a single study at the time of his deposition -- nor was he able to discuss in any detail -- the studies to which he referred. The Arbitrator notes that on cross examination, Dr. Kates admitted that he did not recall whether the studies discussed the length of time an individual would be engaged in the occupation of a firefighter thereby resulting in the development of or acceleration of coronary artery disease. Dr. Kates testified that he did not recall whether or not the studies discussed in any fashion the relationship between firefighting and the development or acceleration of coronary artery disease and the type of safety equipment used by the firefighters. Dr. Kates testified that he last reviewed the data in 2005 and that the purpose of his review of the data at that time was for the letter that he dictated to the Granite City Pension Fund, but that he did not recall where he secured the data. (PX7).

The Arbitrator further finds to be significant the fact that on cross examination, Dr. Kates agreed that he relied on the history from Petitioner that his job activities as a firefighter involved greater stress as a first-arriver and a more difficult work environment than the other firefighters on the force. (PX7). The Arbitrator finds, however, Petitioner did not establish through his testimony at the time of arbitration that his exposures and work as a firefighter exceeded those of an average firefighter.

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 November 2, 2004, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of notice, medical bills, temporary total disability and nature and extent are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) 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

Matthew Gasparovic,
Petitioner,
vs.

NO: 05WC 48262

Granite City Fire Department,
Respondent.

18IWCC0315

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 10, 2017 is hereby affirmed and adopted.

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

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

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

DATED: MAY 23 2018
o041618
KWL/jrc

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GASPAROVIC, MATTHEW
Employee/Petitioner

Case# **05WC048262**
05WC048261

GRANITE CITY FIRE DEPARTMENT
Employer/Respondent

18IWCC0315

On 8/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0728 LAW OFFICES OF THOMAS W DUDA
330 W COLFAX ST
PALATINE, IL 60067

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

18IWCC0315

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

Matthew Gasparovic
Employee/Petitioner

v.

Granite City Fire Department
Employer/Respondent

Case # 05 WC 48262

Consolidated cases: 05 WC 48261

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 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Admissibility of Petitioner's Exhibits 8, 11, 12, 13 & 15**

FINDINGS

On **November 2, 2004**, 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 **$63,024.00**; the average weekly wage was **$1,212.00.**

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

Respondent is entitled to a credit of **$42,582.33** for medical bills 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 of **$42,582.33** for medical bills paid through group insurance under Section 8(j) of the Act.

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

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

Melinda M. Pope-Gillman

Signature of Arbitrator

8/8/17

Date

ICArbDec p. 2

AUG 10 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alfredo Jimenez,
Petitioner,

v.

Case No. 16 WC 21794
16 WC 21795

Homer Tree Services, Inc.,
Respondent.

ORDER

This matter comes before the Commission on Respondent's Motion to Correct Clerical Error in the decision of the Arbitrator filed on June 20, 2017. Due notice having been given, a hearing was held before Commissioner Thomas J. Tyrrell on January 17, 2018 in Chicago, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, hereby grants said motion, for the reasons set forth below.

The record shows that Petitioner filed two claims – 16 WC 21794 and 16 WC 21795, both claims alleging a date of accident of 2/15/16.

The matter proceeded to trial before Arbitrator Steven Fruth on 2/24/17 at which time the parties agreed to proceed on claim 16 WC 21795 only. Specifically, the Arbitrator noted at the commencement of trial that "... we are litigating the issues presented in the application under 16 WC 21795 today. Any issues regarding 16 WC 21794 are deferred to another day." (Arbitration Transcript, p.4).

Arbitrator Fruth subsequently issued a decision in the matter on 6/20/17. However, in the case caption of his decision, the Arbitrator mistakenly referenced claim number 16 WC 21794 instead of the agreed upon 16 WC 21795.

Respondent alleges that it subsequently filed a motion to correct clerical error before the Arbitrator on 7/11/17. However, it appears that the Arbitrator failed to rule upon this motion.

Petitioner eventually filed a Petition for Review on 7/14/17 referencing both claim numbers, 16 WC 21794 and 16 WC 21795.

Respondent thereupon filed the present Motion to Correct Clerical Error on 12/21/17, and the matter was set on Commissioner Tyrrell's review call on 1/17/18.

Based on the above, and given the aforementioned clerical error as to the claim number referenced in the caption of the Arbitrator's decision, the Commission finds that the Arbitrator's decision filed on June 20, 2017 should be corrected to show the proper claim number of 16 WC 21795.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Correct Clerical Error is hereby granted, and the Arbitrator's decision dated June 20, 2017 is corrected to show a claim number of 16 WC 21795.

DATED:

MAY 24 2018

r-01/17/18
TJT/pmo
51

Thomas J. Tyrrell

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Beverly S. Babers,

Petitioner,

vs.

NO: 17WC 1529

18IWCC0316

Aldi, 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 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 August 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 $8,300.00. 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: MAY 24 2018
o051418
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

BABERS, BEVERLY S
Employee/Petitioner

Case# **17WC001529**

ALDI INC
Employer/Respondent

18IWCC0316

On 8/2/2017, 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 1.13% 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:

0294 KATZ NOWINSKI PC
THOMAS E CADY
1000-36TH AVE
MOLINE, IL 61265

2674 BRADY CONNOLLY & MASUDA PC
NOAH P HAMANN
211 LANDMARK DR SUITE C2
NORMAL, IL 61761

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Beverly S. Babers
Employee/Petitioner

v.

Aldi, Inc.
Employer/Respondent

Case # 17 WC 01529

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington , on June 27, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $30,628.52; the average weekly wage was $589.01.

On the date of accident, Petitioner was 62 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $12,524.44 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $12,524.44.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 9, 10, 11, 12, 13, and 14 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid, 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 treatment recommended by either Dr. Sanjay Sundar or Dr. Michael Berry.

Respondent shall pay Petitioner temporary total disability benefits of $392.67 per week for 50 4/7 weeks commencing July 8, 2016, through June 27, 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

July 30, 2017
Date

ICArbDec19(b)

AUG 2 - 2017

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on July 7, 2016. According to the Application, Petitioner was lifting a case of water and sustained an injury to her low back (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a cashier for approximately 40 years. At trial, Petitioner testified that on July 7, 2016, she was sitting in the cashier's check out area. When Petitioner moved a case of water from the check out area to the shopping cart adjacent to it, she felt a "catch" in her left hip.

The Petitioner did not report the accident to Respondent on the day it occurred because she hoped the symptoms would resolve on their own. The symptoms got progressively worse and, by the next morning, Petitioner was experiencing significant pain in her left hip. Petitioner reported the accident to her manager, Tracy O'Brien. An accident report was prepared which stated that Petitioner sustained an injury to her left hip while scanning items and lifting cases of water and "flats" of canned goods into a cart while leaning (Petitioner's Exhibit 16).

Petitioner testified that she previously underwent back surgery in 1994. This was not as a result of a work-related condition and Petitioner was able to return to work to her job as a cashier without restrictions. Petitioner subsequently had three work-related low back injuries while employed by Respondent. However, these three injuries were low back strains for which Petitioner received some physical therapy. No further surgical procedures were either recommended or performed. Petitioner stated that the most recent medical she had for the back pain prior to the accident of July 7, 2016, was in February, 2003.

Petitioner initially sought medical treatment from Dr. Ronald Fiscella, her family physician, on July 8, 2016. Dr. Fiscella's record of that date noted that Petitioner complained of low back, left hip and left leg pain and that Petitioner got hurt at work lifting cases of water. Dr. Fiscella diagnosed Petitioner with low back pain which he attributed to "...repetitive heavy lifting at her job." He authorized Petitioner to be off work and prescribed various medications (Petitioner's Exhibit 1; pp 8-9).

Petitioner was subsequently seen in the ER of Unity Point Health on July 10, 2016. At that time, Petitioner stated she had sustained a low back injury at work four days ago. The history also noted that Petitioner was checking out groceries and was lifting and twisting and hurt her back. An x-ray was ordered which revealed lumbosacral degenerative changes. Petitioner was discharged and directed to return to her family physician (Petitioner's Exhibit 2; pp 2-9).

Dr. Fiscella saw Petitioner on July 14, 2016. At that time, he continued to authorize Petitioner to remain off work and referred her to Dr. Sanjay Sundar, a pain management specialist (Petitioner's Exhibit 1; pp 11-12).

Dr. Sundar initially evaluated Petitioner on August 1, 2016. At that time, Petitioner advised that she injured her back at work on July 7, 2016, while moving a 24 pack of bottled water from a left to right position. Dr. Sundar opined Petitioner had sustained a lumbar strain and he ordered physical therapy. He also stated that epidural steroid/trigger point injections might be indicated (Petitioner's Exhibit 3; pp 2-5).

Dr. Fisella ordered an MRI scan of Petitioner's lumbar spine which was performed on August 9, 2016. According to the radiologist, there was mild disc bulging at four levels of the lumbar spine. In regard to the L5-S1 level, it was noted that there was a significant loss of disc space height and a probable right hemilaminectomy (Petitioner's Exhibit 5).

Petitioner received physical therapy from August 5, 2016, through November 23, 2016. In the entry of August 5, 2016, it was noted that Petitioner injured her back at work on July 7, 2016, when she was placing groceries in a cart (Petitioner's Exhibit 4; p 22).

Petitioner continued to be treated by Dr. Fisella from August through December, 2016. Petitioner consistently stated that she had injured her back at work in July, 2016 (Petitioner's Exhibit 1; pp 13-45).

Petitioner also continued to be treated by Dr. Sundar from August, 2016, through June, 2017. On both August 25 and September 26, 2016, Dr. Sundar administered a trigger point injection in Petitioner's low back (Petitioner's Exhibit 3; pp 14, 20).

At the direction of Respondent, Petitioner was examined by Dr. Kenneth Candido, a pain management specialist, on November 1, 2016. In connection with his examination of Petitioner, Dr. Candido reviewed medical records provided to him by Respondent. Dr. Candido opined that Petitioner sustained a lumbar sprain/strain, but that her pre-existing spondylosis was unrelated to the accident. He also opined Petitioner was at MMI in regard to her lumbar sprain/strain (Respondent's Exhibit 1).

Because of Petitioner's continued symptoms and the fact that conservative treatment had been attempted, Dr. Fisella referred Petitioner to Dr. Michael Berry, an orthopedic surgeon. Dr. Berry evaluated Petitioner on November 10, 2016. According to Dr. Berry's record of that date, Petitioner informed him that on July 7, 2016, while working as a cashier, Petitioner lifted a 24 bottle case of water and experienced an acute onset of severe low back pain. Dr. Berry reviewed the MRI and noted it revealed past surgical changes at L5-S1. He opined Petitioner had diskogenic back pain. In regard to causality, Dr. Berry stated "I do believe that her lifting and twisting a case of water back in 07/2016 significantly contributed to the pain she is currently experiencing. Certainly she had preexisting disk degeneration but based upon her history this was asymptomatic prior to the work accident." (Petitioner's Exhibit 8; pp 2-3).

In regard to further treatment, Dr. Berry recommended Petitioner undergo back surgery. He indicated that an anterior lumbar interbody fusion at L5-S1 was appropriate (Petitioner's Exhibit 8; p 3).

At the direction of Respondent, Petitioner was examined by Dr. Wellington Hsu, an orthopedic surgeon, on December 6, 2016. In connection with his examination of Petitioner, Dr. Hsu reviewed medical records and the MRI scan which had been provided to him by Respondent. Dr. Hsu opined Petitioner had post discectomy L5-S1 degenerative spondylosis and lumbar spondylosis. In regard to causality, Dr. Hsu opined that the accident aggravated Petitioner's post discectomy L5-S1 spondylosis. In regard to further treatment, Dr. Hsu opined that Petitioner was a candidate for an L5-S1 anterior lumbar fusion (Respondent's Exhibit 2).

At trial, Respondent tendered into evidence surveillance video of Petitioner which was obtained on both March 24, and March 27, 2017. The video of March 24, 2017, was approximately one hour long. For a brief period of time, Petitioner was observed walking while carrying what appeared to be some food items. Petitioner did not appear to have a limp and was not wearing a back brace. For the majority of the time in the video, Petitioner was standing at a barbecue grill cooking. The video of March 26, 2017, was approximately five minutes long and Petitioner was again observed walking without a limp and not wearing a back brace (Respondent's Exhibit 5).

At trial, Petitioner testified that she had reviewed the surveillance video of March 24, and March 27, 2017, and agreed that it was her in the video. She stated that Dr. Sundar had prescribed a back brace for her; however, she did not wear it all of the time. She also stated that she typically has good days and bad days.

Respondent provided copies of Dr. Candido's report and the surveillance video of March 24, and March 27, 2017, to Dr. Hsu for his review. Based upon his review of those items, Dr. Hsu stated that they did not impact his opinion in regard to causality. However, based upon his observation of Petitioner in the surveillance video, Dr. Hsu opined that Petitioner had no functional disability upon activities of daily living. Based upon the preceding, Dr. Hsu opined that an L5-S1 fusion procedure was not indicated (Respondent's Exhibit 3).

Dr. Hsu was deposed on June 12, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Hsu reaffirmed the opinions contained in his medical reports. This included the fact that he changed his opinion about the propriety of Petitioner undergoing fusion surgery (Respondent's Exhibit 4; pp 20-21).

On cross-examination, Dr. Hsu agreed that the video he observed was a "snapshot picture" of one hour and 20 minutes of the Petitioner. He also stated that while he observed Petitioner walking and carrying objects, he had no knowledge as to exactly what the objects were (Respondent's Exhibit 4; pp 27-28).

Tyler Ashby testified on behalf of Respondent at trial. Ashby was Respondent's regional manager and had three stores under his supervision. Ashby testified that he reviewed surveillance video of Petitioner obtained on the day of the accident and that it did not show Petitioner lifting/moving any cases of water. However, the surveillance video had been destroyed and was not available at the time of trial. Ashby explained that the Respondent only keeps the videos for 90 days and that time that since lapsed. He also stated that he attempted to make a copy of the video, but that copy was unreadable.

Jennifer Rambo testified on behalf of Respondent at trial. Rambo was Petitioner's immediate supervisor and was present on the day of the accident. She confirmed that Petitioner did not make any statement about sustaining an injury on the day of the accident. She also stated that typically, Petitioner would not lift heavy objects such as cases of water, watermelons, pumpkins, etc.

At trial, Respondent tendered into evidence surveillance video of Petitioner obtained on April 8, and April 9, 2017. The video of April 8, 2017, was very brief and showed Petitioner walking and getting in/out of a car. The video of April 9, 2017, showed Petitioner walking and getting in a car while wearing what they described as high heel shoes. At the time of cross-examination, prior to the showing of the video, Respondent's counsel asked Petitioner if she ever wore high heels and she responded that she did not because of her back symptoms.

Petitioner expressed some doubt whether the individual in the video of April 9, 2017, was her, but conceded that the vehicle in the video appeared to be hers. In any case, Petitioner stated that she did not consider the shoes she wore at that time to be "high heels." The Arbitrator watched the video of April 9, 2017, several times and it was not possible to get a precise measurement of the height of the heel on the shoes. However, the shoes did not appear to be extremely high heeled or a "stiletto" type heel.

At trial, Petitioner walked for approximately 20 feet and did so guardedly and with a slight limp. Petitioner stated that this was how she generally walked even though none of the surveillance videos showed her walking with an observable limp.

Petitioner testified that her back condition was better now than what it was shortly after the accident. Further, Petitioner was uncertain if she wanted to proceed with the fusion surgery that had been recommended by Dr. Berry. Dr. Sundar has continued to treat Petitioner's back condition conservatively with medications and a back brace. Petitioner was wearing a back brace at the time of trial. Petitioner also testified that she has not returned to work since the date of the accident.

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 her employment for Respondent on July 7, 2016.

In support of this conclusion the Arbitrator notes the following:

While the Petitioner did not report the accident to Respondent on the day it occurred, she reported it the following day when her symptoms worsened.

The history of the accident Petitioner provided to the various medical providers was consistent and that they all noted that Petitioner sustained a back injury at work while lifting in July, 2016. Some of them contained the precise date of the accident and others referred to Petitioner

lifting/moving a 24 bottle case of water. However, the fact that Petitioner sustained a work-related injury in July, 2016, was consistently reported to all of Petitioner's medical providers.

Tyler Ashby testified that the surveillance video did not show Petitioner lifting/moving any cases of water on the day of the accident. However, the video was not available at trial.

Jennifer Rambo agreed that Petitioner reported the accident to her the day after it occurred, but that, typically, Petitioner was not required to lift heavy objects.

Given the absence of the surveillance video and the fact that the accident was reported the following day, the Arbitrator is not persuaded by the testimony of either Ashby or Rambo.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of July 7, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner agreed that she had prior low back problems and injuries and underwent low back surgery in 1994. Petitioner also testified that she had fully recovered from the prior back surgery, had been able to return to work without restrictions and that the most recent medical treatment she had prior to July, 2016, was in February, 2003. That testimony was unrebutted.

Respondent's first Section 12 examiner, Dr. Candido, a pain management specialist, opined that Petitioner sustained a lumbar sprain/strain as result of the accident of July 7, 2016, and that her current condition was related to her pre-existing spondylosis.

Respondent's second Section 12 examiner, Dr. Hsu, opined that Petitioner's current condition was causally related to the accident of July 7, 2016. This opinion was unchanged even after his review of the March, 2017, surveillance video.

Petitioner's treating orthopedic surgeon, Dr. Berry, opined that Petitioner's low back condition was causally related to the accident of July, 2016.

The Arbitrator is not persuaded by the opinion of Dr. Candido, a pain management specialist, because it is contrary opinions of both Respondent's second Section 12 examiner, Dr. Hsu, and Petitioner's treating orthopedic surgeon, Dr. Berry, both of whom are orthopedic surgeons.

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

The Arbitrator concludes that all 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 Exhibits 9, 10, 11, 12, 13 and 14, as provided in Sections 8(a) and 8.2 of the Act, subject to the

fee schedule. Respondent shall be given a credit of amounts paid 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 regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment including, but not limited to, continued conservative treatment as recommended by Dr. Sundar or the fusion surgery recommended by Dr. Berry.

In support of this conclusion the Arbitrator notes the following:

Respondent's second Section 12 examiner, Dr. Hsu, initially opined that fusion surgery at L5-S1 was appropriate, but changed his opinion after viewing the March, 2017, surveillance videos. Dr. Hsu agreed that the video could be a "snapshot" of Petitioner's activities. Further, Petitioner stated that she has both good and bad days. The Arbitrator is not persuaded by Dr. Hsu's opinion.

Dr. Berry has recommended Petitioner undergo fusion surgery at L5-S1; however, at trial, Petitioner expressed some reluctance to proceed with the surgery and indicated she may want to obtain further conservative care.

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 50 4/7 weeks commencing July 8, 2016, through June 27, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been under active medical care and has been unable to return to work.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Penny Wight,
Petitioner,
vs.

NO: 16WC 4325

18IWCC0317

Keystone Steel & Wire,
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, 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 September 7, 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: MAY 24 2018
o051418
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIGHT, PENNY
Employee/Petitioner

Case# **16WC004325**

KEYSTONE STEEL & WIRE
Employer/Respondent

18IWCC0317

On 9/7/2017, 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:

0192 CUSACK GILFILLAN & O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Penny Wight
Employee/Petitioner

v.

Keystone Steel & Wire
Employer/Respondent

Case # 16 WC 04325

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on July 27, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On December 16, 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 $77,450.88; the average weekly wage was $1,489.44.

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

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $4,364.28 for other benefits, for a total credit of $4,364.28.

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

ORDER

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

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

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

William R. Gallagher, Arbitrator

September 2, 2017
Date

ICArbDec p. 2

SEP - 7 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of December 16, 2014, and that Petitioner sustained "repetitive trauma" to the "left hand, arm, right hand, arm" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in May, 1992, as a laborer. A couple of years thereafter, Petitioner transferred to another area of the plant where her primary duty was driving a forklift. That has remained Petitioner's job since then up to and including the present. The basis of Petitioner's claim was that her job duties operating the forklift required the repetitive use of both arms which caused her to sustain cubital tunnel syndrome in both arms/elbows.

Petitioner testified in detail about the use of both of her arms when she drove the forklift. Petitioner stated she would use her left hand to operate the steering wheel when she drove the forklift. The left hand was constantly on the steering wheel when the forklift was moving. The steering wheel also had a knob on the wheel which rotated which made operation of the steering wheel somewhat easier. Petitioner used her right hand primarily the index and middle fingers, to operate the forklift controls. These controls were used whenever spools of wire or other product was being moved. Petitioner stated she would operate the hand controls hundreds of times during a typical workday.

At trial, Petitioner reviewed a job description which had been received into evidence. Petitioner testified that the frequency of various duties performed by her in the job description were not accurate. Specifically, Petitioner stated that the job description that she had to twist/rotate her upper trunk from right to left as being "rarely" was inaccurate and it really was "frequently." Petitioner stated that the job description that she had to pick/pinch with her fingers as being done "rarely" was inaccurate and that it should have been "frequently" or hundreds of times every day (Petitioner's Exhibit 7).

The job description also noted that Petitioner was subject to continuous vibration and performed repetitive work. Petitioner agreed that those portions of the job description were accurate (Petitioner's Exhibit 7).

Petitioner testified that in 2007 she was elected to a union grievance committee as well as a safety committee. Because of her union activities, Petitioner had to spend a considerable amount of time away from work to tend to union business. Respondent tendered into evidence a breakdown of Petitioner's hours for 2014, 2015 and 2016. For those three years Petitioner was paid for 6,801.75 hours, of which 4,362.75 hours were for union business and the remaining 2,439 hours were for work performed by Petitioner for Respondent. The percentage of time Petitioner spent tending to union business for that three year time period was computed to be 64.14% (Respondent's Exhibit 3). On cross-examination, Petitioner agreed that the aforestated figures were accurate.

Mike Millard testified on behalf of the Respondent at trial. Millard became Petitioner's supervisor in 2007 and knew the specifics of Petitioner's job duties. Millard confirmed the accuracy of the data regarding Petitioner's union/work hours for 2014, 2015 and 2016. Further, Millard stated that Petitioner's time spent tending to union duties would have been similar in 2012 and 2013. For the years 2007 through 2011, Millard stated Petitioner's union activities would have been about 50% of her total hours.

Millard testified Petitioner would typically work two to two and one-half shifts per week operating the forklift or 16 to 20 hours per week. He estimated Petitioner drove the forklift approximately 90% of the time; however, he stated Petitioner would pick up and deliver approximately 200 loads a day. It was when Petitioner was either picking up or delivering the loads that she would use her right hand to operate the controls. Millard stated that this would take about 10 seconds each time that function was performed. Accordingly, he estimated Petitioner would operate the controls with her right hand about 33 minutes during a typical workday.

Petitioner had a prior workers compensation claim for bilateral carpal tunnel syndrome. In regard to that condition, Petitioner's primary treating physician was Dr. Jeffrey Garst, an orthopedic surgeon. Dr. Garst performed right and left carpal tunnel release surgeries on March 16, 2006, and May 15, 2006, respectively (Petitioner's Exhibit 2). The carpal tunnel syndrome case was settled for 12 1/2% loss of use of each hand on July 16, 2007 (Respondent's Exhibit 3).

Petitioner subsequently had bilateral hand/arm symptoms and underwent EMG/nerve conduction studies on October 1, 2010, and December 20, 2010. Both studies were negative for cubital tunnel syndrome (Respondent's Exhibit 2; Deposition Exhibits 6 and 7).

At the direction of Respondent, Petitioner was examined by Dr. Mitchell Rotman, an orthopedic surgeon, on January 24, 2011. In connection with his examination of Petitioner, Dr. Rotman reviewed medical records regarding Petitioner's carpal tunnel syndrome condition including the EMG/nerve conduction studies of October and December, 2010. Dr. Rotman opined Petitioner's current symptoms were not work-related (Respondent's Exhibit 2; Deposition Exhibit 3).

Petitioner was subsequently seen by Dr. Garst on November 25, 2014. At that time, Dr. Garst opined Petitioner had probable bilateral recurrent carpal tunnel syndrome. He referred Petitioner to Dr. Frank Russo, for EMG/nerve conduction studies (Petitioner's Exhibit 2).

Dr. Russo saw Petitioner on December 9, 2014, and performed EMG/nerve conduction studies at that time. He noted Petitioner's prior history of bilateral carpal tunnel syndrome and surgeries and that Petitioner advised that she did not have complete relief of her symptoms. He opined that the studies were positive for mild bilateral ulnar neuropathy at the elbow, a finding that was not present in the prior study of October 1, 2010. He also opined that the studies were positive for mild dysfunction/neuropathy bilateral of median nerve at the wrist with slight improvement when compared to the prior study of October 1, 2010 (Petitioner's Exhibit 3).

Dr. Garst saw Petitioner on December 16, 2014 (the date of manifestation alleged in the Application) and he reviewed the EMG/nerve conduction studies. Dr. Garst opined Petitioner had bilateral cubital tunnel syndrome and possible recurrent bilateral carpal tunnel syndrome. Dr.

Garst's record of that date did not contain any reference to Petitioner's work activities and he did not provide an opinion as to causality (Petitioner's Exhibit 2).

Dr. Garst initially treated Petitioner's bilateral cubital tunnel syndrome conservatively. However, Dr. Garst ultimately performed ulnar transposition surgeries on the right and left elbows on April 30, 2015, and November 18, 2015, respectively (Petitioner's Exhibits 2 and 5).

At the direction of Respondent, Dr. Dru Hauter, performed a medical records review on June 10, 2015. In his review of the medical records, Dr. Hauter noted Petitioner had diabetes and been previously diagnosed with Dupuytren's Contracture. He opined Petitioner's bilateral cubital tunnel syndrome was not caused, aggravated or advanced by her job activities (Petitioner's Exhibit 12).

At the direction of Respondent, Petitioner was examined by Dr. Troy Karlsson, an orthopedic surgeon, on June 14, 2016. In connection with his examination of Petitioner, Dr. Karlsson reviewed medical records provided to him by Respondent as well as Petitioner's job description. When seen by Dr. Karlsson, Petitioner informed him that she worked 40 to 70 hours per week, used both arms continuously and had done so for about 20 years. Dr. Karlsson opined that there was not a causal relationship between Petitioner's job activities and Petitioner's bilateral cubital tunnel syndrome. He noted that Petitioner was not required to hold her arms in a highly flexed position for long periods of time and there was no highly repetitive motion that put stress on the ulnar nerve (Respondent's Exhibit 2; Deposition Exhibit 14).

Dr. Karlsson also prepared an AMA impairment rating report. In that report, Dr. Karlsson opined Petitioner had zero percent (0%) impairment of both upper extremities (Respondent's Exhibit 2; Deposition Exhibit 15).

Dr. Garst was deposed on November 23, 2016, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner's bilateral cubital tunnel syndrome, Dr. Garst's testimony was consistent with his medical records. When questioned about Petitioner's job duties, Dr. Garst stated it was his understanding Petitioner worked as a "material handler," and he did not have a good history of Petitioner's job duties. Petitioner's counsel then asked Dr. Garst a hypothetical question in which he stated Petitioner operated a forklift 90% of the time while at work and the operation of that required the repetitive and active use of both the left and right hands/arms. Dr. Garst testified that Petitioner's work activities were a contributing factor (Petitioner's Exhibit 1; pp 8-14).

Dr. Karlsson was deposed on February 13, 2017, and his deposition testimony was received into evidence at trial. Dr. Karlsson's testimony was consistent with his medical report and he reaffirmed the opinions contained therein, in particular, that Petitioner's bilateral cubital tunnel syndrome was not related to her work activities. Dr. Karlsson testified that Petitioner had informed him that she worked a minimum of 40 hours per week up to 70 hours per week and that the operation of the forklift required the repetitive motion of both of her arms. Petitioner did not inform Dr. Karlsson of the amount of time she spent performing union activities, but he stated that if Petitioner's operation of the forklift was less than 50% of the work time, this would be inconsistent with the history Petitioner had provided to him (Respondent's Exhibit 2; pp 12-16).

Dr. Karlsson also reviewed photographs of the various forklifts Petitioner had operated. He noted that the controls operated by both hands were not in a location that would have required repetitive full extension or flexion of the elbows on a frequent basis (Respondent's Exhibit 1; pp 12-13).

At trial, Petitioner testified she had been able to return to work to her regular job for Respondent. She still experiences some tenderness in the elbows, but otherwise has minimal symptoms.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive, injury arising out of and in the course of her employment for Respondent that manifested itself on December 16, 2014, and that her current condition of ill-being is not related to her work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that the operation of the forklift required the continuous repetitive use of both upper extremities.

Initially, the Arbitrator notes that approximately two-thirds (2/3) of Petitioner's work hours for 2014 through 2016 were spent performing union activities, not work for Respondent.

In regard to the years 2012 and 2013, Petitioner's supervisor, Mike Millard, credibly testified that the amount of time Petitioner would have spent performing union activities during that period of time would have been about the same as it was in 2014 through 2016. In regard to the years 2007 through 2011, Millard testified it would have been about 50% of Petitioner's total hours. While Respondent only produced documentary evidence with specific numbers of hours for 2014 through 2016, the Arbitrator finds Millard's testimony in regard to Petitioner's work hours to be credible.

Petitioner's testimony as to the continuous repetitive use of her hands/arms while working for Respondent is also questionable. As was noted by Millard, Petitioner only used her right hand to operate controls for approximately 33 minutes per workday.

Respondent's Section 12 examiner, Dr. Karlsson, opined that Petitioner's bilateral cubital tunnel syndrome was not work-related. Part of the basis of Dr. Karlsson's opinion regarding causality was his review of various forklifts driven by the Petitioner and he noted that Petitioner's elbows would not have been in a fully extended or flexed position on a frequent basis.

When examined by Dr. Karlsson, Petitioner informed him that she worked for Respondent 40 hours a week, up to 70 hours per week. Obviously, that was inconsistent with the number of hours Petitioner actually worked for Respondent based upon the number of hours she engaged in union activities.

Dr. Garst opined Petitioner's bilateral cubital tunnel syndrome was work-related; however, this opinion was based on the incorrect assumption that Petitioner worked 90% of the time driving a forklift with the continuous and repetitive use of her upper extremities while doing so. Dr. Garst had no knowledge whatsoever of Petitioner's union activities, and the amount of time she spent on same.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Karlsson, in regard to causality, to be more persuasive than that of Dr. Garst.

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

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rodney Hadley,

Petitioner,

vs. NO: 14 WC 22980

Menasha Packaging Co.,

Respondent.

18IWCC0318

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, notice, causation, temporary total disability, 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).

Petitioner, a 53-year-old forklift operator, testified that as part of his job he "... would take packages off the conveyor as they come down and put them on a pallet if needed and shrink wrap them, put them in storage, put the boxes in storage." (T.14). He indicated the boxes varied in size and could weigh "... from 30 to 40 pounds, 50 to 60 pounds." (T.14-15). He noted he had worked for Respondent for three years and that during that period he had never filed a workers' compensation claim. (T.15). However, he later indicated that in "2000-something" he filed a workers' comp claim in regards to his neck when he was working for a company in Kansas City. (T.43-44). He denied ever filing a workers' compensation claim for his back. (T.43).

Petitioner testified that on 2/6/14 he had "... a box on the conveyor, oversized, and when it got down to the end of the T of the conveyor, it got stuck because the conveyor comes up sometimes and it won't go back down. So I was pushing, I was pushing the box, and I heard

18IWCC0318

something pop." (T.15). Petitioner indicated that he worked the third or night shift from 11:00 p.m. to 7:00 a.m. (T.16). He indicated that following the incident he notified someone "... I don't know his name. He worked the second shift – third shift, I mean. Or was it the first shift? First shift I think." (T.16). He noted that the representative from Menasha Packaging who was present at trial, Jonathan Hickson, was not the supervisor on duty at that time. (T.16).

Mr. Hickson testified that he works for Menasha Packaging as a shipping manager and that he has been employed by Respondent for "[g]oing on 20 years this September." (T.53). He noted that on 2/6/14 he would have been the shipping manager at Respondent. (T.53). He indicated that Petitioner worked for him on the third shift as a checker/loader. (T.53-54). Mr. Hickson noted that from what he remembered he was Petitioner's supervisor for 2 or 3 years. (T.54). However, on cross, when asked whether he was Petitioner's supervisor, Mr. Hickson responded: "I was his manager. I managed the department." (T.58-59).

When asked whether Petitioner ever advised him or anyone at Respondent about a work injury occurring on 2/6/14, Mr. Hickson replied: "I do not recall." (T.54). He then stated that he "... was never notified." (T.54). Mr. Hickson also indicated that Petitioner never mentioned hurting his back and that he never completed a first report of injury. (T.54). In addition, he pointed out that it is his usual custom to complete such a form as a supervisor when an employee reports an injury at work. (T.55).

On cross, Mr. Hickson agreed that he worked the first shift, from 7:00 am to 4:00 pm, and that he was not physically there at the time Petitioner was working. (T.58). However, he maintained that he was in charge of Petitioner's shift. (T.58). When asked if there were other supervisors there at the time Petitioner allegedly was injured, Mr. Hickson replied: "Yes, I have a shipping clerk that's there." (T.58). When asked why this individual was not at the hearing, Mr. Hickson noted that "[h]e no longer works for the company" given that he was laid off due to downsizing. (T.58).

Mr. Hickson indicated that to his knowledge Petitioner had not filed a workers' comp claim before. (T.59). He also conceded that it was possible Petitioner reported this to somebody other than himself. (T.59). Mr. Hickson indicated that after a worker reports an injury he is sent to the medical facility, which he assumed was Physicians Immediate Care at the time. (T.59). However, Mr. Hickson could not recall seeing any fit-for-duty slips for Petitioner. (T.60). He also denied giving Petitioner a light-duty position. (T.60). However, he acknowledged that "... I was aware he was on light duty, but I've never seen any of the documentation... If the paperwork was handled, it was through human resources. I never saw any of the documentation." (T.60). He also agreed that if someone is working a light-duty job they had to have gotten hurt somewhere. (T.61-62). In addition, he agreed that it was possible that an accident report was written and given to human resources without his knowledge. (T.62).

On re-direct, Mr. Hickson indicated that his shipping clerk never reported a work injury to him concerning Petitioner. (T.63). He also noted that the shipping clerk in question had reported work injuries to him involving other workers in the past. (T.63). On re-cross, Mr. Hickson acknowledged that packages sometimes get caught up on the conveyor belt and that it was possible that Petitioner had to manually move a box. (T.64).

Petitioner indicated that following the incident he requested medical care and that the company sent him to Physicians Immediate Care. (T.17). In a Physicians Immediate Care record dated 2/10/14, it was noted that "[t]he patient presents with a chief complaint of constant pain of the left lower back since Thu[rsday], Feb[.] 06, 2014… The patient reports it was the result of an injury, which was work related, which had a sudden onset. The patient had no similar problems in the past. This is not the result of a motor vehicle accident. Patient denies that any non-work related event or illness possibly contributed to or is related to development of symptoms. Patient was attempting to straighten a box that had twisted by forcibly pushing it. He felt a sudden pain in his lower back on the left side. The patient continued to work the rest of the shift. He states that the pain increased today when he first reported for work. He wen[t] to a local emergency room. [H]e was given medications and time off, he was sent to our clinic. The patient also reports tingling as an abnormal symptom related to the complaint." (PX8). Triage notes indicate that "[p]atient states that he was trying to push a box that was stuck and felt a pinch in his back." (PX8). The diagnosis was lower back pain. (PX8). An MRI was ordered and Petitioner was to return to the clinic on 2/13/14 for a re-check. (PX8). It was also noted that Petitioner may return to sit down work only on 2/11/14, and that this restriction was in effect until 2/13/14. (PX8).

Petitioner denied going to the emergency room on 2/6/14. (T.47). He also indicated that he returned to work for Respondent following his visit to PIC in a light-duty position involving washing and cleaning out pails. (T.19). He indicated that this job caused him pain "[b]ecause I was leaning, leaning, and it was cold that night" working the night shift. (T.20).

Petitioner followed up with Physicians Immediate Care on 2/14/14. In an office note on that date, it was recorded that "[t]he patient describes the severity [of lower back pain] as moderate, which is unchanged since last visit." (PX8). It was also noted that "[p]atient was attempting to straighten a box that had twisted by forcibly pushing it. He felt a sudden pain in his lower back on the left side. The patient continued to work the rest of the shift. He states that the pain increased today when he first reported for work." (PX8). He was diagnosed with a lumbosacral strain and told that he was "[f]it for duty with the following restrictions: Avoid prolonged sitting. Avoid prolonged squatting. Avoid prolonged bending over. Avoid prolonged twisting. No lifting over shoulder greater than 20 lbs[.] No lifting from waist to shoulder greater than 20 lbs[.] No lifting below waist greater than 20 lbs[.] No pulling or pushing greater than 30 lbs[.] Use proper lifting techniques as instructed." (PX8).

Petitioner returned to Physicians Immediate Care on 2/20/14 at which time it was noted that "[t]he patient describes the severity as 10/10, with 10 being the worst imaginable, last visit it was Moderate." (PX8). Petitioner was to follow up on 2/25/14 and was referred to Dr. Andrew Zelby for consultation. (PX8). It was also noted that Petitioner was fit for sit down work only starting 2/20/14, and that this restriction was in effect until 2/25/14. (PX8).

Petitioner returned to Physicians Immediate Care on 2/25/14 at which time it was noted "[t]he patient describes the severity as 5/10, with 10 being the worst imaginable, which has improved since last visit when it was 10/10. The problem is made better by medication and made worse by movement." (PX8). The diagnosis was sprain/strain of the lumbar region that was "[s]table/[i]mproved." (PX8). Petitioner was told he was fit for duty without restrictions starting 2/25/14. (PX8). It was also noted that physical therapy was ordered and an MRI of the

18IWCC0318

lumbar spine was still pending approval. (PX8).

In a Physicians Immediate Care record dated 3/4/14, Petitioner was also told he was fit for duty starting 3/4/14 with the following restrictions: avoid bending over entirely, avoid twisting entirely, no lifting over shoulder greater than 10 lbs., no lifting from waist to shoulder greater than 10 lbs. and no lifting below waist greater than 10 lbs. (PX8). It was also noted that the "MRI will be done today." (PX8).

An MRI of the lumbar spine performed on 3/4/14 was interpreted as evidencing 1) left herniation L4-5 with underlying bulge and minimal degenerative spondylolisthesis narrowing of the foramina, and mild spinal stenosis; 2) diffuse bulge L2-3 and L3-4 narrowing the foramina, and 3) minimal degenerative spondylolisthesis L5 narrowing the foramina. (PX4b).

In a Physicians Immediate Care record dated 3/11/14, it was noted that the MRI showed left-sided herniation at L4-L5 with spondylolisthesis, narrowing of the foramina and mild spinal stenosis. (PX8). Petitioner was to continue with physical therapy and return to the clinic on 3/25/14 for a recheck. (PX8). He was also told that he was fit for duty starting 3/11/14 with the same restrictions as noted at his prior visit. (PX8). In addition, Petitioner was once again asked to visit Dr. Zelby in consultation. (PX8).

In a Physicians Immediate Care record dated 4/1/14, it was recorded that "Pt states his back pain has improved but still feels pain. Pt states he is compliant w/ meds. Pt has not been to work due to personal reasons. He has not been able to attend PT for the same personal/family reasons." (PX8). The diagnosis was noted to be a sprain/strain of the lumbar region with "[n]o [w]orkup." (PX8). Petitioner was yet again asked to visit Dr. Zelby in consultation. (PX8). He was also told that he was fit for duty starting 4/1/14 with the following restrictions: avoid prolonged bending over, no lifting over shoulder greater than 15 lbs., no lifting from waist to shoulder greater than 15 lbs. and no lifting below waist greater than 15 lbs. (PX8).

In a Rush University Medical Center Emergency Department record dated 4/4/14 it was noted that Petitioner presented with a persistent cough since 3/25/14, congestion, shortness of breath, fever, myalgias, non-bloody diarrhea and decreased food intake. (PX4b). Petitioner agreed that the treatment at Rush was unrelated to his injury. (T.26).

Petitioner returned to Physicians Immediate Care on 4/15/14 at which time it was noted that "Pt states pain is feeling better from last visit and has been compliant w/ meds but states they help "kinda sorta". [H]e still has pain but notes he is better. He would like to try regular duty." (PX8). Petitioner was then told he was fit for duty without restrictions starting 4/15/14. (PX8).

Petitioner testified that he finally obtained approval and was initially evaluated by Dr. Zelby on 4/18/14. (T.27). In a report dated 4/18/14, Dr. Zelby recorded that the patient "... reports an injury at work on February 6, 2014. He pushed a load but [sic] he estimates weighed 200-300 pounds on a conveyor belt, but the load got stuck and he developed low back pain. He went to a hospital on Cicero Avenue, but is not certain of which hospital. He reports he was given medications and a few days off work. He followed up with the clinic, where he was given additional medications, was released back to work, and had a couple of months of physical

18IWCC0318

therapy. He does not feel much better following this treatment. Currently, he has pain in his low back which intermittently radiates down the posterior aspects of both thighs. He has intermittent numbness in his entire left leg, and feels his left leg is weak... The pain is constant and not improving. The pain is exacerbated with fixed postures and prolonged walking. The pain is relieved with a change of position and medication... He reports a prior low back injury in 2005 after lifting bags of concrete. He has had back and leg pain since that time, but the pain is worse after his more recent accident. He also reports a neck injury in 2007 or 2008." (PX6).

For his part, Petitioner denied having had any prior low back pain. (T.46-47). When asked specifically about any prior injury in 2005, Petitioner responded: "[t]hat's my neck." (T.47).

Dr. Zelby also noted that "[a]n MRI of the lumbar spine from March 4, 2014 shows degenerative disc disease at L4-5 L5-S1 without loss of disc space height. There are minimal broad based bulging discs at L2-3 and L3-4. At L4-5 there is a broad-based and left disc/osteophyte complex. There is significant facet arthropathy with fluid in the joints and severe left greater than right foraminal stenosis. There is the suggestion of a trace spondylolisthesis at this level. At L5-S1, there is a broad based posterior vertebral osteophyte." (PX6). Dr. Zelby's impression was 1) lumbar spondylosis, 2) spondylolisthesis-acquired, and 3) herniated lumbar disc. (PX6).

Dr. Zelby concluded that "Mr. Hadley has low back bilateral leg pain, degenerative lumbar spondylosis as well as a herniated L4-5 disc, and a suggestion of a spondylolisthesis seen on his MRI." (PX6). X-rays were prescribed and Petitioner was to follow up with his primary care physician with respect to his blood pressure. (PX6). In addition, Petitioner was instructed to stop smoking and maintain a more healthy body weight for the general health of the spine. (PX6). Dr. Zelby indicated that Petitioner "... may work at this time with lifting up to 20 pounds occasionally and 10 pounds frequently." (PX6).

Petitioner returned to Physicians Immediate Care on 4/22/14 at which time it was noted that "Pt states he went to back specialist and they told him it looks like his bones were rubbing against each other. Prolonged walking makes pain worse. Pt is compliant w/ meds and states they do give relief from pain. The patient saw Dr. Zelby and he rec[ommended] a surgery." (PX8). Petitioner was to return to the clinic for recheck on 5/6/14 and was told he was fit for duty without restrictions starting 4/22/14. (PX8).

Petitioner returned to Dr. Zelby on 4/28/14 at which time it was reported that he "... developed an exacerbation of posterior left leg pain last week after walking 3 blocks to complete his lumbar spine x-rays. He has no pain in his right leg. He has no numbness, but feels his left leg is weak... He is currently working full duty." (PX6). Following his exam and review of the lumbar x-rays from 4/24/14, Dr. Zelby noted that "Mr. Hadley continues to complain of low back pain, and has developed an exacerbation of left leg pain. We reviewed the findings of his x-rays and their relationship to his symptoms. We explained that his spondylolisthesis at L5-6 shows some movement. We discussed pursuing a series of lumbar epidural steroid injections or a lumbar fusion as an ALIF at L5-6 and L6-S1 with pedicle screw fixation. However, we have asked Mr. Hadley to stop smoking without the use of any nicotine replacement therapy prior to

18IWCC0318

surgery and remain off nicotine for a minimum of 6 months following surgery to give him the best chance possible for healing of his fusion." (PX6). Dr. Zelby gave Petitioner a prescription for a series of lumbar epidural steroid injections and noted that Petitioner "... would like to continue to work full duty until we see him back in the office in 4 weeks." (PX6). Petitioner subsequently underwent the aforementioned series of injections on 5/15/14. (T.31-32).

Petitioner returned to Dr. Zelby on 5/28/14 at which time it was recorded that Mr. Hadley "... feels about the same as when we saw him previously. He reports he had a lumbar epidural steroid injection a few weeks ago, and this gave him 4 days of relief before the pain returned. Currently, he had pain on the left side of his low back which radiates down the posterior aspect of his left leg to his calf. He has a four-day history of tingling in his left foot, and feels his left leg is weak when the pain is severe... He is working full duty. He continues to smoke, but reports he is down to 2 cigarettes a day, 1 in the morning and 1 in the evening." (PX6). Dr. Zelby noted that "[w]e discussed pursuing an additional 1-2 lumbar epidural steroid injections, but Mr. Hadley indicated he has no interest in trying any additional injections. He continues to smoke, but reports he will completely stop smoking within the next week. We explained we do not want to recommend surgery, specifically at L5-6 and L6-S1 ALIP, until he completely stops smoking without the use of nicotine replacement therapy... He many continue to work full duty until we see him back in the office in 4 weeks." (PX6).

Petitioner returned to Dr. Zelby on 6/25/14 at which time it was noted that "[d]espite physical therapy, pain medications, and a trial of 1 epidural steroid injection, the patient continues to find his symptoms to be significantly bothersome... He is here today to further discuss surgery... He continues to work his regular job in a full duty capacity. The patient states that although he has cut back on smoking, he continues to smoke approximately 2 cigarettes in the morning and 2 in the evening each day. He feels that once a surgical date is set he will be able to stop completely, and he has stopped smoking on several occasions in the past, once for almost 5 years." (PX6). Dr. Zelby noted that Mr. Hadley "... feels his symptoms are intolerable and he does not feel that he can live with this degree of pain indefinitely... He would like to proceed with surgery, but would like to wait until the beginning of September because of personal commitments [in] August. He will be scheduled for an anterior lumbar interbody fusion at L4-5 and L5-S1 on September 2, 2014... Because of his smoking history and a multilevel fusion, we have also ordered an external bone stimulation braced [sic] for him to wear after surgery... He may continue to work full duty until surgery." (PX6).

Petitioner agreed surgery was initially scheduled for 9/2/14, and that Dr. Zelby released him to return to full duty work, but not from treatment, while awaiting surgery. (T.33-34). He also noted that his primary care physician currently monitors his blood pressure and that he has since stopped smoking. (T.28-29,32).

Petitioner agreed that his employment with Respondent was terminated at the end of June 2014. (T.49-50). When asked why he was terminated from his job, Petitioner replied: "... I had a fiancée that was in the hospital, and she was on her death bed. And I asked, I went to ask the human resources if there was something we could do so I would be able to be there with her at the hospital. And they said just go on and use the vacation time that you have, that you had. And that's what I did, and that's how I got terminated." (T.50).

18IWCC0318

In a Physicians Immediate Care office note dated 7/1/14, it was recorded that the "[p]atient is released from our care for this condition. The patient will be followed by Dr[.] Andrew Zelby. A surgery on his back is anticipated on 9/2/2014." (PX8). It was also noted that Petitioner was fit for duty with the following restrictions: avoid prolonged bending over, avoid prolonged twisting, no lifting over shoulder greater than 10 lbs., no lifting from waist to shoulder greater than 10 lbs. and no lifting below waist greater than 10 lbs. (PX8).

Petitioner subsequently sought a second opinion with Dr. Michael Foreman. (T.34). In an office note dated 7/2/14, Dr. Foreman recorded that Petitioner presented "... with a chief complaint of low back pain subsequent to a work related injury on February 4 [sic], 2014... Mr. Hadley was on duty as a forklift operator, when he was pushing a box on a conveyor belt and it suddenly got stuck, causing a loud popping noise in his low back. He did not have immediate pain but did record [sic] the incident to his supervisor, and continued to work. Over the following two days he experienced increasing low back pain and on 2/6/14 he went to an unspecified medical clinic where he was examined, was given an injection in his low back and was discharged for outside follow up." (PX4a). Upon examination, Dr. Foreman noted tenderness and hypertonicity upon palpation bilaterally, range of motion limited by pain in all ranges, especially extension, and positive straight leg raising, Yeoman's and Kemps tests for localized pain bilaterally. (PX4a). The diagnosis was lumbar sprain and lumbar radiculopathy. (PX4a). Petitioner was given instructions for ice and warm soaks, to avoid strenuous activity and to obtain outside diagnostics. (PX4a). He was also to consider physical therapy and return for re-evaluation with Dr. Foreman on 7/3/14. (PX4a).

In an office note dated 7/3/14, Dr. Foreman recorded that "Norco provides some temporary relief. However, patient is running low. Patient was educated about risks and benefits of surgery by Dr. Zelby and is considering surgery. However, patient would like a second opinion. Has not had any nerve testing of lower extremity." (PX4a). Dr. Foreman ordered nerve testing to assess nerve injury and referred the patient to a spine specialist for a second opinion. (PX4a). Petitioner was to remain off work pending re-evaluation on 8/1/14, and was told to avoid strenuous activities and apply moist heat as instructed. (PX4a).

In a consultation report dated 7/7/14, Dr. Elton Dixon recorded that the patient "... sustained a work related injury on 02/06/14 where he works as a forklift driver and was pushing a heavy box on a jammed conveyor belt and felt a pop in his low back. The next day he started having low back pain radiating into his left lower extremity that is exacerbated with prolonged sitting, prolonged standing, prolonged walking, going up and down stairs, bending and lifting. He denies any problems controlling his bowel or bladder. He has no weakness in his lower extremities. The patient was in physical therapy and it was discontinued due to exacerbation of his symptoms. He is presently being managed with hydrocondone, Avapro, compound cream to localized back pain and an anti-inflammatory." (PX4b). Upon exam, Dr. Dixon noted that "[t]he back was nontender although straight leg raises sitting and lying were positive on the left... Sensation was decreased in the left L5 distribution..." (PX4b). Dr. Dixon's assessment was "[s]tatus post work related injury with low back pain and left lower lumbar radicular symptoms." (PX4b). Dr. Dixon noted "Mr. Hadely is in need of an EMG and nerve conduction study of the lower extremities to assess lumbar radiculopathy to help with management of his complaint." (PX4b). The ensuing EMG of the left lower extremity was interpreted as abnormal, noting

18IWCC0318

"[l]eft L5 radiculopathy and no neuropathy was seen in the lower extremities." (PX4b).

Petitioner agreed that Dr. Foreman then referred him to Dr. Kern Singh at Rush Orthopaedics. (T.36). In a "Workers' Compensation" report dated 7/14/14, Dr. Singh recorded that Petitioner had worked for Respondent for the past three years and that "[o]n 02/06/2014 he reports he went to move a heavy box that was stuck on a conveyor belt when he felt a 'pop' in his lower back, immediately followed by significant low back pain, favoring the left side. Also, developed left buttock and posterior thigh pain with numbness and tingling into the foot. He rates his low back and leg pain today a 7-8/10... He describes his symptoms today as constant, stabbing, burning pain at the base of the lower spine that radiates across both sides of the lower back into the buttock. He reports pain and numbness, mostly left, posterior thigh into the knee. He does notice with certain positions he will have numbness and tingling extending into his foot. He denies weakness and walking as well as standing. He finds some relief with short bursts of sitting as well as finds the need to lean forward on countertops as well as utilizing the shopping cart to help with his pain. He is currently taking naproxen as well as Norco for breakthrough pain. He does find temporary relief with this." (PX5). Dr. Singh's diagnosis was 1) L4-5 grade I/II dynamic spondylolisthesis with moderate-to-severe stenosis, 2) L5-S1 isthmic grade 1 spondylolisthesis. (PX5). Dr. Singh noted that "[t]he patient has exhausted conservative management in the form of physical therapy and epidural injections resulting in minimal to no relief of his symptoms. On exam, he has left TA and EHL weakness which correlates with the significant stenosis at L4-5 with a dynamic GI/II spondylolisthesis at L4-5 laminectomy, TLIP, and posterior spinal fusion for 08/05/2014 at Rush Hospital." (PX5).

In an office note dated 8/1/14, Dr. Foreman recorded that the "[p]atient is scheduled for surgery by Dr[.] Singh on 8-5. Using all medications with some mild relief." (PX4a). It was noted that "EMG results reviewed which reveal L5 radiculopathy" and that "[l]umbar spine MRI reveals multilevel disc disease with disc bulging disc herniation stenosis spondylosis[.] Patient denies symptoms requiring medical care prior to accident, and denies history of prior knowledge of condition." (PX4a). The diagnosis was lumbar strain, lumbar radiculopathy, lumbar disc herniation, lumbar spondylosis and lumbar spinal stenosis. (PX4a). Petitioner was to be off work pending re-evaluation on 9/11/14 and "[m]ay return for post op rehab if cleared by Dr[.] Singh sooner." (PX4a).

At the request of Respondent, Petitioner visited Dr. Stanford Tack on 8/13/14 for purposes of a §12 examination. Dr. Tack generated a report dated 8/28/14 wherein he noted that "[t]he history is suggestive of a prior back injury in 2005 with persistent chronic back pain, suggesting that h[is] increased back pain reported by Mr. Hadley is a result of his occupational incident of February 2014 and would reflect exacerbation of a pre-existing symptomatic lumbar degenerative condition, specifically, degenerative spondylolisthesis with spinal stenosis at L4-5 and L5-S1." (RX2). Dr. Tack indicated that "[t]he history provided suggests that an exacerbation of low back pain occurred on February 6, 2014 when Mr. Hadley was pushing a box of material down a conveyor belt. However, the history ... does indicate a previously symptomatic low back condition as noted by Dr. Zelby. As such, the relationship of the current symptoms to the occupational incident would reflect an exacerbation of a pre-existing condition." (RX2). Dr. Tack felt the treatment rendered, and occupational restrictions imposed, "... were rendered in response to his report of increased symptoms related to the occupational

18IWCC0318

incident of February 6, 2014." (RX2). Dr. Tack also opined that the exacerbation of the pre-existing condition requiring treatment ended when Petitioner was allowed to return to work without restriction on 4/29/14. (RX2).

In an office note dated 9/11/14, Dr. Foreman recorded that "[p]atient reports surgery was canceled due to lack of approval and that he has an attorney who is trying to get authorizations. He is using pain meds regularly and requests something stronger. Expresses frustration and a desire to get the surgery so he can move forward with his life." (PX4a). It was noted that the patient was "[s]table pending surgery, fair pain control with high doses of narcotics." (PX4a). It was noted that Petitioner was off work pending re-evaluation on 10/15/14 and he "[m]ay return for post op rehab if cleared by Dr. Singh sooner." (PX4a).

In a report dated 9/11/14, Dr. Singh noted that he had reviewed additional records, including the IME of Dr. Tack, and that "I do agree with the majority of Dr. Tack's opinions ... [H]owever, I would like to provide significant discrepancy which is the fact that Dr. Tack believed the patient's symptoms were no longer persistent as of April 29, 2014 when Dr. Zelby returned Mr. Hedley to unrestricted occupational activities. I do not believe that the patient's willingness to return to back to work without restriction is indicative of the patient being asymptomatic. He has medical treatment that postdates his return to work as he was persistently symptomatic. It is my belief that the patient did sustain the aggravation of an underlying degenerative condition as outlined by Dr. Tack during the February 10 [sic], 2014 injury for his pre-existing condition at L4-5 and L5-S1 and I believe that he was symptomatic post his return to work in April 2014. This is an important distinction as I believe it preserves the continuity of the patient's pain complaint from the onset of his work related injury on February 10 [sic], 2014 to the present time. As such, I do believe the patient's need for surgical intervention at the L4-5 and L5-S1 level, specifically laminectomy and fusion is appropriate, reasonable and cause-related to his work related injury... I do believe that surgical intervention will allow this individual to return back to work in a gainful fashion and help alleviate his persistent symptomatology which has been present since February 10 [sic], 2014." (PX5).

In an office note dated 10/15/14, Dr. Foreman recorded that "[p]atient reports surgery is still pending and his attorney is working on this still. Using all meds regularly and requesting refill." (PX4a). Once again, it was noted that Petitioner was off work pending re-evaluation and that he "[m]ay return for post op rehab if cleared by Dr. Singh sooner." (PX4a).

In an office note dated 11/26/14, Dr. Foreman recorded that the "[p]atient reports he was hospitalized for stress and anxiety over pain and lack of funds. Is on meds, floxatine 20. Also needing all pain meds regularly though TENS and Lumbar orthoses both help a little with pain and activity tolerance." (PX4a). Petitioner was to remain off work pending re-evaluation on 1/9/15. (PX4a).

In an office note dated 10/14/15, Dr. Foreman recorded that "[p]atient reports hearing is still pending. No change in symptoms. Still needing all pain meds regularly though TENS and Lumbar orthoses both help a little with pain and activity tolerance. Refill requested. On meds for anxiety, feeling a little better re stress." (PX4a). Once again, Petitioner was to remain off work pending re-evaluation on 2/18/15. (PX4a).

18IWCC0318

Petitioner returned to Dr. Foreman on 2/18/15, 3/18/15, 4/29/15, 6/10/15, 7/29/15, and 8/26/15 with no change in status. (PX4a).

Petitioner was last seen by Dr. Foreman on 10/7/15 at which time it was noted that Mr. Hadley was "[o]ff work pending clearance by Dr. Singh. Discharged my care to Dr[.] Singh and/or a pain specialist. May return following surgery if rehab ordered and desired.... Try to wean oral narcotics as able." (PX4a).

Petitioner indicated that in all three (3) physicians have recommended to him that he undergo surgery – namely, Drs. Singh, Foreman and Zelby. (T.39). He also noted that he would have the recommended surgery if it was awarded, and that he would like to have it done by Dr. Singh. (T.44-45). He stated that he still currently takes the Naproxen prescribed by Dr. Foreman. (T.48).

Dr. Kern Singh testified that he is a board certified orthopedic spine surgeon. (PX1, p.7). Dr. Singh indicated that he first saw Petitioner on 7/14/14 following a referral from Dr. Foreman. (PX1, p.9). At the time of his exam, Dr. Singh recorded a history of injury on 2/6/14 when the patient "... went to move a heavy box that was stuck on a conveyor belt when he felt a pop in his lower back and followed by subsequent pain, particularly on the left side." (PX1, p.10). He noted that Petitioner had undergone six weeks of physical therapy and received one injection that had provided only transient or minimal pain relief. (PX1, pp.10-11). He also noted that the patient had seen Dr. Andrew Zelby who had recommended fusion surgery at L4-5 and L5-S1. (PX1, p.11).

Following his examination and review of the lumbar MRI dated 3/4/14, Dr. Singh noted a diagnosis of L4-5 grade I/II dynamic spondylolisthesis with moderate to severe stenosis, grade I L5/S1 isthmic spondylolisthesis. (PX1, p.12). Dr. Singh noted that Petitioner was symptomatic at the time of his initial exam and that he "... had symptoms consistent with spinal stenonis and a spondylolisthesis. People typically have back and leg pain. He traces out leg pain and L5 distribution which would correlate with his stenosis. In addition, the forward flexing or forward flexion posturing is a known position where a patient with stenosis likes to position themselves. It helps to alleviate some of the pressure on the nerve root." (PX1, pp.13-14).

Dr. Singh noted that he recommended surgery in the form of an L4-5 and L5-S1 fusion, noting that Petitioner "... has a two level stenosis at the L4-5 and L5-S1, so he needs a laminectomy to help decompress his spinal canal. A laminectomy alone in a settling of a slippage or a small listhesis could result in further worsening, so that's why I recommended the fusion to be incorporated." (PX1, p.14). Dr. Singh also recommended that Petitioner remain off work until the surgery was performed. (PX1, p.14).

Dr. Singh noted that he generated another report, on 9/14/14, after reviewing additional records, including the IME report of Dr. Stanford Tack. (PX1). Dr. Singh indicated Dr. Tack agreed that Petitioner had sustained an aggravation of his underlying degenerative condition, particularly at the L4-5 level, and that an L4 to S1 laminectomy or lumbar decompression and spinal fusion was indicated. (PX1, p.16). However, Dr. Singh noted that he disagreed with Dr. Tack's opinion that Petitioner's symptoms were related to his degenerative condition and not the

work event, and that they had resolved by April of 2014. (PX1, pp.16-17). Instead, Dr. Singh believed that "... Mr. Hadley reports a mechanism of injury that would be plausible for an aggravation of his pre-existing condition. He has pain complaints that are anatomic in nature that correlate with the L5 nerve root distribution. So he has very reasonable pain complaints. That correlates with his MRI findings. Furthermore, he actually has motor weakness, so he has objective examination findings in his legs, and particularly on his left side. He returns to work because he has a desire to return to work. That further in my mind helps establish the reasonableness of his pain complaints and the onset of his pain complaints. I think all of those substantiate that he has an onset of pain that began after a specific event, and that his pain complaints thereafter were objective in nature, or at least objectifiable in nature." (PX1, pp.17-18).

Dr. Singh testified that he was of the opinion that Petitioner's condition of ill-being, at least up until when he saw him, was causally related to the incident on 2/6/14, and that "... the mechanism of injury provided by Mr. Hadley to me was a reasonable mechanism for aggravation of that underlying condition." (PX1, pp.19-20). With respect to whether Petitioner was currently capable of working, Dr. Singh testified that "I felt that in light of his motor weakness and his significant stenosis, I do not feel that he is currently capable of working." (PX1, p.20). As far as future medical treatment is concerned, Dr. Singh testified that "I believe that [Petitioner] requires a two level laminectomy and fusion to address the L4-5 and the L5-S1 spinal stenosis and spondylolisthesis. Thereafter, he will require physical therapy from approximately one month postoperatively, to approximately six months postoperatively, followed by an FCE and two to four weeks work conditioning, with determination of return back to work based upon radiographic fusion, with maximum improvement to occur approximately seven to eight months postoperatively." (PX1, p.21). Dr. Singh indicated that the need for this care was causally connected to the 2/6/14 work injury. (PX1, p.21).

On cross, Dr. Singh agreed that his diagnosis included two degenerative conditions that pre-existed the work injury of 2/6/14. (PX1, p.28). When asked about a reference in Dr. Tack's report to a prior back injury in 2005, with continued back and leg pain since that time, Dr. Singh responded: "I guess I would just say it would not surprise me that Mr. Hadley had symptoms before his work injury as his stenosis was significant. I do believe that he has strength weakness in his leg. I don't believe that was present before, otherwise that may limit his level of functioning from beforehand. So I don't necessarily – I wouldn't necessarily agree that he had a back injury in 2005 and was symptomatic from that. But my opinion still relies upon the fact that he had objective weakness in that distribution." (PX1, pp.31-32). However, Dr. Singh acknowledged that he did not have any data or findings to show what Petitioner's motor strength was before the work injury. (PX1, p.32).

Dr. Singh also noted that Petitioner "... is now reporting, at least for the first time that I am aware of, that he is unable to perform activities because of the pain intensity and his weakness. That would be unique and different than any hypothetical scenario that you presented to me before where he was able to work throughout that time period, at least what he reports to me the duration of working was, at least for the past three years." (PX1, pp.33-34).

18IWCC0318

When asked whether Petitioner's return to work following the accident in question could be an indication that the aggravation he had suffered had resolved, Dr. Singh responded: "No. That would be indicative of his desiring and his – the validity of his effort that he wants to go back to work and has entertained that. But at least how he reports to me is that he was still symptomatic when returning back to work." (PX1, p.35).

On re-direct, Dr. Singh testified that it was his understanding that Petitioner was working in a full duty capacity up until 2/6/14. (PX1, p.40). He also indicated that he has not seen any medical records that show Petitioner was actively treating for his lower back and leg pain in the days, months or years immediately preceding his 2/6/14 work injury. (PX1, p.40). It was also his understanding that Petitioner consistently treated for his low back and associated leg pain following the work injury up to the time he saw him. (PX1, pp.40-41). In addition, he agreed that Petitioner's subjective complaints were consistent with his subjective findings upon examination and per the diagnostic testing. (PX1, p.41).

Dr. Singh indicated that he believes that the surgery will improve Petitioner's symptoms, and that he is prepared to perform same if it is authorized. (PX1, p.41). Dr. Singh noted that "I think that he's seen three separate spine surgeons who have all recommended surgery. The only issue here is causation, not a medical one. He requires the surgery. I think that's uniform in recommendations. So I do believe it will benefit him." (PX1, p.42).

On re-cross, Dr. Singh agreed that in a lumbar fusion it is preferable that patients don't smoke, noting that "[t]he recovery doesn't change much, but it does decrease the likelihood for a successful fusion. Typically in a nonsmoker, it may be up to 98 percent chance for successful fusion; in a smoker, around 90 to 92 percent." (PX1, pp.42-43).

Board certified orthopedic surgeon Dr. Stanford Tack testified that he saw Petitioner at the request of the Respondent on 8/13/14. (RX1, p.6). Following his examination, he prepared a report dated 8/28/14. (RX1, p.6). Dr. Tack recorded a history of injury on 2/6/14 while pushing a box on a conveyor belt when he felt a pop in his lower back." (RX1, p.7). Dr. Tack noted that Petitioner related that he initially had no pain, and that he began having pain several days later. (RX1, p.7). Dr. Tack also indicated that Petitioner "… states he has a history of previous low back pain, but that he had received no treatment for it. His only other medical history was diabetes." (RX1, p.8). However, Dr. Tack stated that in reviewing the record of Dr. Zelby dated 4/18/14, the latter noted that Petitioner had "… a prior history of a back injury in 2005, and that he had back and leg pain since that time; but that the symptoms were currently worse after his accident." (RX1, p.9).

Following his examination and review of the record, including radiographs and an MRI of the lumbar spine, Dr. Tack opined that "Mr. Hadley appeared to be experiencing back pain and left lower extremity radicular symptoms related to a spondylolisthesis and spinal stenosis at L4-5 with a probable contribution of a chronically degenerative disc with facet arthrosis at L5-S1." (RX1, p.11). He agreed that these diagnoses, including the degenerative changes and spinal stenosis noted on x-rays and the MRI, pre-existed the work accident on 2/6/14 and were not caused by same. (RX1, p.11). Dr. Tack testified that "… based on the history that was provided by the patient in the medical records, it's very suggestive that there was at a minimum an

18IWCC0318

exacerbation of a pre-existing degenerative condition[,] which at least according to the records, was in fact symptomatic prior to the accident." (RX1, p.12). Dr. Tack defined exacerbation as "... a transient change in symptoms without an alteration of the actual condition; as opposed to an aggravation, which I use to mean there's a permanent change in the underlying condition." (RX1, pp.12-13). Dr. Tack noted that "... I say that in large part because, at least according to the history in the medical record, this was a previously symptomatic condition. And it was subsequently symptomatic, perhaps somewhat more so requiring some new form of treatment, but appeared to diminish in severity back to a point where – from the best I can tell, it appeared to be similar to the same complaints that he reported to Dr. Zelby that he had beforehand; in other words, ongoing back and leg symptoms." (RX1, p.13).

With respect to the two-level fusion surgery recommended by both Dr. Zelby and Dr. Singh – namely, a laminectomy and fusion -- Dr. Tack testified that "I think that the surgery based on, you know, the recurrence and progression of symptoms over time would be an appropriate surgery for the condition that was demonstrated on both x-rays and MRI. But clearly this is a chronic progressive condition, and the treatment – the surgery is the treatment of the underlying degenerative condition, which frankly was present on the date of injury. And the natural history of that condition is that over time it gets worse, and most patients end up having surgical treatment of this." (RX1, p.16).

Dr. Tack also felt that after 4/29/14 Petitioner's "... exacerbation had resolved. And at that point, what was being treated was the underlying chronic condition. And, therefore, I would relate all subsequent treatment to the underlying condition, which was actually present on the date of injury." (RX1, p.17).

On cross, Dr. Tack agreed that the treatment to date was reasonable and necessary, noting that he didn't "... have any problems with anything that was done, with the exception of some of the medications he was dispensed, but that's a minor issue." (RX1, pp.20-21). He also reiterated that "... to the extent that [Petitioner] has ongoing back pain and leg pain that he finds functionally problematic, the surgeries [Drs. Zelby and Singh] are recommending is the appropriate treatment for that condition in that circumstance." (RX1, p.21). He noted that "... if this was a patient of mine and I was treating him for these symptoms and felt that it was bad enough to have surgery, the surgery would in fact be a laminectomy and fusion at L4 to L5, which is what I think what's being proposed by both doctors, Singh and Zelby." (RX1, p.24). He also noted that he reviewed the actual MRI images and would agree that Petitioner had symptoms consistent with spinal stenosis and spondylolisthesis. (RX1, p.24).

Dr. Tack testified that "[t]he reality is somebody with spondylolisthesis and spinal stenosis, identical to what [Petitioner] has on his imaging, could experience an exacerbation or an aggravation of their symptoms doing virtually anything; they could bend over to tie their shoe, they could cough or sneeze, they could be in a motor vehicle accident... So I don't have any objections to the notion that this incident that occurred while he was, you know, moving some things on a conveyor belt might have precipitated an exacerbation of symptoms. I don't dispute that in any way, shape, or form." (RX1, p.25).

18IWCC0318

Dr. Tack acknowledged that he did not review any medical records between 2005 and the date of his deposition that would show that Petitioner was undergoing ongoing treatment, presumably prior to the date of accident. (RX1, p.21). He also agreed that based on his notes he was told by Petitioner that the latter was working in a full-duty capacity prior to the alleged accident in February of 2014, and that he was not provided with any records disputing that. (RX1, pp.25-26).

Based on the above, and the record taken as a whole, the Commission reverses the Arbitrator and finds that Petitioner's current condition of ill-being relative to his lumbar spine is causally related to the accident on 2/6/14. The Commission points out that in support of her decision the Arbitrator mistakenly noted that "... the medical records are void of any mention of a pop" at the time of the accident. (Arb.Dec. [Addendum], p.3). The Commission finds that the medical records actually contain histories recorded by no less than three providers referencing the reporting of a "pop" or "popping" noise in his lower back at the time of the incident – namely, the office notes by Drs. Foreman, Dixon and Singh dated 7/2/14, 7/7/14 and 7/14/14, respectively. (PX4a, PX5). However, irrespective of any reference to a "pop", the records consistently note a history of work-related injury wherein Mr. Hadley was attempting to push a box that was stuck on a conveyor belt, including the Physician's Immediate Care record dated 2/10/14 – or only four (4) days after the incident in question.

The Commission also notes that while Dr. Zelby's initial report dated 4/18/14 noted a prior history of low back injury in 2005 after lifting bags of concrete, and the fact that Petitioner supposedly had back and leg pain ever since that time, there is absolutely no other evidence to substantiate such a claim. More importantly, there is no evidence to show that Petitioner experienced any lower back and/or leg complaints thereafter, much less sought treatment for same or lost any time from work during the period leading up to the accident on 2/6/14.

Furthermore, the Commission finds persuasive the opinion of Dr. Kern Singh to the effect that Petitioner's condition of ill-being is causally related to the accident in question and that the recommended surgery in the form of an L4 to S1 laminectomy/decompression and spinal fusion was indicated. The Commission notes that even Dr. Tack, Respondent's §12 examining physician, was willing to concede that Petitioner suffered an aggravation or exacerbation of his underlying degenerative disc condition, albeit a temporary one, as a consequence of the accident. In addition, Dr. Tack agreed that the treatment to date was reasonable and necessary, and that the surgery recommended by Drs. Zelby and Singh is appropriate. (RX1, pp.20-24).

As a result, the Commission finds that Petitioner is entitled to the reasonable and necessary medical expenses relating to the accident as set forth in PX2, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act, as well as prospective medical treatment pursuant to §8(a) in the form of the surgery presently recommended by Dr. Singh and initially offered by Dr. Zelby.

Furthermore, given the above determination as to causation, the Commission finds that Petitioner is entitled to temporary total disability benefits from 7/4/14, when Dr. Singh took him off work, through 8/9/16, the date at arbitration, given that Petitioner remains off work per Dr. Singh pending surgery, for a period of 109-5/7 weeks.

18IWCC0318

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $635.05 per week for a period of 109-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses as set forth in PX2, 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. Singh, including surgery at L4-L5 and L5-S1, 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.

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: MAY 24 2018
o:4/3/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

HADLEY, RODNEY
Employee/Petitioner

Case# **14WC022980**

MENASHA PARKAGING COMPANY
Employer/Respondent

18IWCC0318

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
DEREK S LAX
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY A WELCH
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

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)

RODNEY HADLEY
Employee/Petitioner

v.

MENASHA PACKAGING COMPANY
Employer/Respondent

Case # **14** WC **022980**

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 Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **8/09/16**. 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 _____

18IWCC0318

FINDINGS

On the date of accident, **2/6/14**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$49,846.16**; the average weekly wage was **$958.58**.

On the date of accident, Petitioner was **53** 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 **$NA** for TTD, **$NA** for TPD, **$NA** for maintenance, and **$NA** for other benefits, for a total credit of **$NA**.

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

ORDER

Because the Petitioner reached MMI on 4/29/14, Petitioner failed to prove any lost time as result of the injury sustained on February 6, 2014, TTD benefits are denied.

Petitioner failed to prove that his current condition of ill-being is causally related to the accidental injury sustained on February 6, 2014, Respondent has paid all reasonable and necessary medical services prospective medical treatment is denied.

Respondent shall be given a credit of payments made in Respondent's Exhibit No. 4 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.

Deborah L. Simpson

Signature of Arbitrator

February 2, 2017
Date

ICArbDec19(b)

FEB 14 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rodney Hadley,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 22980**
	)	
Menasha Packaging Company,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on February 6, 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. They agree that in the year preceding the injuries, the Petitioner earned $49,846.16, and that his average weekly wage was $958.58.

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) Was timely notice of the accident given to Respondent; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is Petitioner entitled to TTD; (5) Is the Respondent liable for the outstanding medical bills listed in the list of outstanding bills attached to Joint Exhibit #1; and (6) Is Petitioner entitled to prospective medical care.

STATEMENT OF FACTS

The Petitioner worked as a forklift operator for the Respondent on February 6, 2014. The Petitioner took packages off of a belt and put them on a pallet to be shrink wrapped. The packages weighed between 40 and 60 pounds. He had worked in this position for three years prior to the accident date of February 6, 2014. His shift was from 11:00 p.m. to 7:00 a.m. He worked third shift. The Petitioner alleged that on February 6, 2014, he was injured while working. He alleged that while operating a forklift, the product box on the conveyor got stick. He pushed it and heard a pop. The Petitioner testified that he notified the third shift supervisor/dispatcher, name unknown, regarding the accident.

The Petitioner testified that he requested medical treatment and went to Physicians Immediate Care Clinic. (Petitioner's Exhibit No. 8.) His initial treatment was four days later on February 10, 2014. The records from February 10, 2014, indicate the Petitioner did present to the ER on February 6, 2014. However, no medical records were entered at trial to substantiate this claim. The Petitioner testified that he was able to drive himself to Physicians Immediate Care. *Id.* He complained of low back pain, and an MRI was ordered. The MRI of the lumbar

spine was performed on March 4, 2014. The MRI of the Petitioner's spine shows longstanding conditions such as spondylosis and stenosis. Physical therapy was ordered by Physicians Immediate Care. *Id.*

On March 11, 2014, the Petitioner noted that he was much better. (Petitioner's Exhibit No. 8.) He denied any radiation. He was referred to Dr. Zelby. On April 1, 2014, Petitioner noted that he did not begin physical therapy as ordered due to personal issues. *Id.* On April 15, 2014, Petitioner noted that his pain was better, and he wanted to be returned to work in a full-duty position. *Id.*

He was referred to Dr. Andrew Zelby for further evaluation. (Petitioner's Exhibit No. 6.) The Petitioner admitted to a prior back injury in 2005 and back and leg pain since. Dr. Zelby diagnosed the Petitioner with spondylolisthesis at L4-L5. On April 28, 2014, Dr. Zelby re-evaluated the Petitioner and recommended an epidural steroid injection. *Id.* He performed an injection on May 15, 2014. The Petitioner reported four days of relief. On May 28, 2014, it was noted the Petitioner was working full duty. *Id.* Dr. Zelby recommended that he continue working without any restrictions. Dr. Zelby recommended an anterior lumbar fusion but delayed the surgery for Petitioner to discontinue smoking. *Id.*

On July 1, 2014, he was returned to work with a ten-pound lifting restriction by Physicians Immediate Care. (Petitioner's Exhibit No. 8.) On July 3, 2014, Petitioner was seen by Dr. Michael Foreman, who dispensed anti-inflammatories and pain medication. (Petitioner's Exhibit No. 4.) He referred the Petitioner to Dr. Kern Singh. *Id.* He was seen by Dr. Singh on July 14, 2014, who recommended a two-level fusion L4-5 and L5-S1. (Petitioner's Exhibit No. 5.)

The Petitioner was examined by Dr. Stanford Tack pursuant to Section 12 on August 28, 2014. (Respondent's Exhibit No. 2.) Dr. Tack performed a physical examination of the Petitioner and a review of his medical records. He found no causal connection between petitioners' complaints and his work injury. *Id.* He diagnosed the Petitioner with degenerative spondylosis at L4-L5 with associated degenerative spinal stenosis at the L4-L5 level. This was consistent with a prior back injury in 2005 with persistent chronic back pain. The symptoms Petitioner experienced in February 2014 were an exacerbation of a pre-existing condition. The exacerbation requiring treatment ended when he returned to work without restrictions by April 29, 2014. Id. *Id.* Dr. Tack's evidence deposition was taken on June 3, 2015. (Respondent's Exhibit No. 1.)

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)

In support of the Arbitrator's decision relating to (C), did an accident occur that 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 that the Petitioner did sustain an accident that arose out of and in the course of Petitioner's employment by the Respondent. Timely notice was given in accordance with the Illinois Workers' Compensation Act, and the Respondent offered no other testimony with regards to the Petitioner suffering an accident somewhere else. Moreover, the mechanism of accident is consistent with this type of injury. The Petitioner was gainfully employed by the Respondent for several years at the time of this occurrence and it occurred while he was in the scope of his employment.

The Arbitrator finds that the Petitioner did sustain an accident on February 6, 2014 that arose out of and in the course of Petitioner's employment with the Respondent.

In support of the Arbitrator's decision relating to (E), was timely notice of the accident given to Respondent, the Arbitrator finds the following facts:

The Arbitrator heard the Petitioner's testimony and reviewed all the evidence and finds that timely notice of the accident on February 6, 2014, was given by the Petitioner to the Respondent.

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 incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Based on the above the Arbitrator finds that the Petitioner failed to prove that his current condition of ill-being in regards to the lumbar spine is causally related to the alleged injury.

First, the Petitioner offered no testimony as to experiencing any increased pain or discomfort after the alleged accident. The Petitioner testified that during the alleged accident he felt a pop. However, the medical records are void of any mention of a pop. The Petitioner advised the medical providers at Physicians Immediate Care that he did not experience any pain

until February 10, 2014, when he arrived at work. This is a four-day gap from the alleged incident of February 6, 2014. Further, the Petitioner denied any prior low back injury during trial. However, this was not accurate, as he admitted to Dr. Zelby of a prior injury in 2005 with continuous pain complaints and left leg radiation. (Petitioner's Exhibit No. 6.)

The Petitioner was examined by Dr. Stanford Tack on August 13, 2014. (Respondent's Exhibit No. 1.) Dr. Tack opined that the Petitioner suffered nothing more than a temporary exacerbation of the pre-existing spondylosis and stenosis in his lumbar spine. He opined that the Petitioner returned to his pre-existing baseline when he was released to return to work full duty on April 29, 2014.

When the facts of an injury are in dispute, the records most contemporaneous with the alleged accident date are the most relevant and persuasive. In the case at hand, the medical records from the actual date of accident note that the Petitioner made no mention of any injury to his lumbar spine to any medical provider until February 10, 2014. The medical records most contemporaneous with the accident date are most persuasive and clearly demonstrate that the Petitioner did not suffer an injury to his lumbar spine at work on February 6, 2014. The Petitioner has never received any diagnosis, her complaints are all subjective, and no objective testing has substantiated any of her complaints or decrease in abilities as testified to at the time of trial.

In support of the Arbitrator's decision relating to (J), were the medical services that were provided reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services; and (K) is the Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Based on Section F above, the Arbitrator finds that the Respondent is not responsible for any medical care, past or prospective. As the Arbitrator noted in Section C, the Petitioner failed to prove causation in regards to his current medical services recommended. Further, based on Section F, the Petitioner had a pre-existing condition and prior injury. Any medical treatment was related to his pre-existing condition, which was degenerative in nature. Additionally, based on the opinions of Dr. Tack, the Petitioner's suggested treatment would not be related to his work duties. (Respondent's Exhibit Nos. 1 and 2.) Based on the above, the Arbitrator finds that the Petitioner is not entitled to any past or prospective medical care pursuant to Section 8(a).

Further, the Petitioner's attorney is alleging outstanding medical charges of $4,623.04. (Arbitrator's Exhibit No. 1.) Petitioner's Exhibit No. 2 admitted at trial shows an outstanding balance from Oak Park Medical Center ($2,525.00), Associated Medical Centers ($1,918.00) Rush University Medical Center ($111.04), Mt. Sinai Hospital ($0.00 balance), Physicians Immediate Care ($0.00 balance), Neurological Surgery ($0.00 balance), Midwest Orthopaedics ($0.00 balance), and Elmhurst Memorial ($69.00). Any outstanding balance alleged due and owing by the Petitioner was incurred after he reached MMI and returned to work full duty on April 29, 2014. Respondent made medical payments with no liability for remaining bills. (Respondent Exhibit No. 5.)

In support of the Arbitrator's decision relating to (L), temporary total disability benefits, the Arbitrator finds the following:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Based on Section (F) above, the Arbitrator finds that no additional TTD benefits are due to the Petitioner for failure to prove causal connection within the meaning of the Workers' Compensation Act. Therefore, the Arbitrator finds that the Petitioner failed to prove entitlement to TTD benefits and denies all requests for TTD.

ORDER OF THE ARBITRATOR

Because the Petitioner reached MMI on 4/29/14, Petitioner failed to prove any lost time as result of the injury sustained on February 6, 2014, TTD benefits are denied.

Petitioner failed to prove that his current condition of ill-being is causally related to the accidental injury sustained on February 6, 2014, Respondent has paid all reasonable and necessary medical services prospective medical treatment is denied.

Respondent shall be given a credit of payments made in Respondent's Exhibit No. 4 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.

Deborah L. Simpson

Signature of Arbitrator

February 2, 2017
Date

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

Sharon Ragland,

Petitioner,

vs. NO: 13 WC 1749

State of Illinois/Department of Human Services,

18IWCC0319

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, 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 December 5, 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: MAY 24 2018
TJT:yl
o 5/14/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAGLAND, SHARON
Employee/Petitioner

Case# **13WC001749**

STATE OF ILLINOIS-DHS
Employer/Respondent

18IWCC0319

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:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

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

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

1745 DEPT OF HUMAN 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

DEC 5 - 2016

Ronald A. Piccinini, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0319

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

Sharon Ragland
Employee/Petitioner

v.

State of Illinois DHS
Employer/Respondent

Case # **13** WC **1749**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **November 28, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Petitioner's condition of ill-being in the **left knee** *is* causally connected to the injury, but Petitioner's condition of ill-being in the **right knee and lumbar spine** *is not* causally connected to the injury.

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

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$58,788.00** and the average weekly wage was that of **$1,130.54**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$32,139.23** 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 **$32,139.23.**

Respondent is entitled to a credit of **$ALL AMOUNTS PAID** for medical bills paid through its group medical plan under Section 8(j) of the Act.

ORDER

Respondent shall pay **$2,621.04** for medical services (*i.e.*, those provided by Benton Community Healthcare for a date of service of December 5, 2012 and Memorial of Carbondale for a date of service of November 12, 2015) 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 Petitioner. Respondent shall pay the unpaid, related medical expenses (*i.e.*, those provided by Benton Community Healthcare for a date of service of December 5, 2012 and Memorial of Carbondale for a date of service of November 12, 2015) according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall pay Petitioner temporary total disability benefits of **$753.69/week** for the timeframe of **March 9, 2013 through October 30, 2014**, a total of **85 6/7 weeks**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$32,139.23** 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 **$32,139.23.**

Respondent shall pay Petitioner the sum of **$678.32**/week for a further period of **86 weeks,** as provided in Section 8(e) of the Act, because the injuries sustained caused **40% loss of use of the left leg.** Related thereto, Respondent is entitled to a credit of 7.5% loss of use of the left leg in light of the prior settlement on the same body part as set forth in the Settlement Contract Lump Sum Petition and Order in 06 WC 28871, *Sharon Ragland v. Pinckneyville Correctional Center.*

Respondent is entitled to a credit of **$See Exhibits** for medical bills paid through its group medical plan under Section 8(j) of the Act.

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

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

Melinda M. Cline-Sullivan
Signature of Arbitrator

12/1/16
Date

ICArbDec p. 2

DEC 5 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sharon Ragland
Employee/Petitioner

Case # **13** WC **1749**

v.

Consolidated cases: **N/A**

State of Illinois DHS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that her accident occurred on November 28, 2012. She testified that on the date of accident, she went to the copier and it needed paper. She testified that she took a case of paper to the copier, squatted and set the box down. She testified that when she went to stand up, her left knee popped loudly. She testified that she filled out an incident report.

After testifying regarding the extensive medical treatment for her left and right knees and her lumbar spine, Petitioner testified that she is still going to pain management and is seeing a neurologist. She testified that she has not been able to return to work, and that she ended up retiring on May 31, 2016 because she did not think she could do the job anymore. She denied ever having been offered a position within her restrictions with Respondent, but testified that she worked up until approximately one week before her first left knee procedure in March of 2013.

On cross examination, Petitioner testified that she had experienced left knee problems one time when she worked at Pinckneyville when she had moved a box of files and her knee started hurting. She testified that she went to see a doctor and had an injection, but denied having any issues after that. She testified that the accident happened somewhere between 2001 and 2006. She denied ever having had any right knee problems before and when asked if she had any prior low back complaints, Petitioner responded that if she did, it was so far back she would not even remember.

The medical records of Benton Community Healthcare were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on June 23, 2014 for abdominal pain, and the assessment was that of abdominal pain and low blood potassium. At the time of the May 2, 2014 visit, Petitioner was seen for sinus issues, and the assessment was that of acute sinusitis and anemia. At the time of the April 15, 2014 visit, Petitioner presented with issues of fatigue and anemia. The assessment was that of fatigue. At the time of the April 4, 2014 visit, Petitioner was seen for follow-up of her bilateral knee replacement. It was noted that Petitioner was still having a lot of breakthrough pain and was concerned. Petitioner's Norco and Zofran were refilled, and a script for Tramadol was issued for breakthrough pain as needed. It was noted that Petitioner was still taking Lexapro as her stress/anxiety had been brought on by the chronic pain from the knees due to work. At the time of the February 25, 2014 visit, Petitioner was seen for pre-operative clearance and hypertension. It was noted that Petitioner's pain occurred constantly and was worsening in the bilateral knees, that associated symptoms included decreased mobility and swelling and that she was scheduled to undergo a total knee replacement on March 4, 2014. Petitioner was cleared for surgery. (PX1).

The records of Benton Community Healthcare reflect that Petitioner was seen on February 14, 2014 for follow-up from the emergency room, diarrhea and depression. It was noted that Petitioner was having issues with abdominal pain, and the assessment was that of gastroenteritis, diarrhea, nausea and depression. At the time of the January 10, 2014 visit, Petitioner presented to discuss pain medication and was seen in follow-up on chronic knee pain. It was noted that Petitioner had been off work for nine months and was being forced to return in order to secure her job, and that she was having a lot of bilateral knee pain and was in need for a knee replacement but was still waiting for approval. The assessment was that of chronic knee pain. At the time of the September 23, 2013 visit, Petitioner was seen for acute sinus symptoms, cough and an upper respiratory infection. The assessment was that of acute sinusitis. At the time of the May 20, 2013 visit, Petitioner was seen for possible chicken pox and medication refills. The assessment was that of rash and other non-specific skin eruption. At the time of the March 8, 2013 visit, Petitioner was seen for a pre-operative exam related to a March 15, 2013 left knee procedure. Petitioner was cleared for surgery. (PX1).

The records of Benton Community Healthcare reflect that Petitioner was seen on December 5, 2012 for left knee pain. It was noted that the onset was five days ago, that the problem was worsening and that the pain was sharp. It was noted that Petitioner stated that she was kneeling down to set a ream of paper in a box, and that when she stood up she noted a tenderness in the knee but did not think too much of it. It was noted that the next morning she noticed knee pain on the right anterior knee and that it had continued. The Nursing Comments noted that Petitioner reported an audible pop while standing back up after moving papers at work. The assessment was that of left knee pain, and Petitioner was referred to orthopedics. Included within the records was the interpretive report for x-rays of the left knee performed on December 5, 2012, which were interpreted as within normal limits. (PX1).

The medical records of Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on February 5, 2016 by Dr. Davis for follow-up, at which time it was noted that she continued to have multiple back and lower extremity complaints. It was noted that Petitioner was obviously distressed with her persistent symptoms and it was very concerning for her. It was noted that Petitioner stated that her knees were still uncomfortable, but that she also had other symptoms related to her back and legs. The impression was that of persistent symptoms after bilateral total knee arthroplasties and lumbar discectomy. It was noted that Dr. Davis assured Petitioner that her x-rays looked good, and that one possibility could be a metal allergy. It was noted that Petitioner was to continue with her home exercise program and was unable to return to pre-operative work status at that time. At the time of the December 3, 2015 visit with Dr. Davis, it was noted that Petitioner presented for knee pain on the left greater than the right, and that she stated that the symptoms had been chronic non-traumatic. It was noted that in addition to knee pain on the left greater than the right, Petitioner was also experiencing weakness, limping, decreased mobility, night pain, difficulty going to sleep and tenderness. It was noted that Petitioner reported that her pain was about 50% in her knees and 50% in her back, and that she was continuing to pursue diagnosis and treatment options for her back but was frustrated by her lack of answers at that point. It was noted that Petitioner reported that she continued to have weakness in her legs and was continuing to fall on average 3-4 times per week. The impression was that of knee pain and weakness after bilateral TKAs and neuropathy. It was noted that Dr. Davis felt Petitioner would benefit from a consultation with Dr. Newell. Included within the records was an interpretive report for a bone scan performed on November 12, 2015 at Memorial Hospital of Carbondale, which was interpreted as revealing (1) bilateral knee prosthesis are seen; no scintigraphic evidence of loosening or infection; (2) degenerative disease lower lumbar spine and both AC joints. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by Dr. Davis on October 29, 2015 for knee pain on the left greater than the right. It was noted that Petitioner was also experiencing decreased mobility, limping, weakness and swelling. It was noted that Petitioner

stated that she hurt all the time, and that she was tolerating the pain but was concerned that she could not lift her left foot very high off the ground. It was noted that Petitioner also reported that she fell a lot (3-4 times per week) because she was tripping over everything. It was noted that Petitioner had a history of back surgery done by Dr. Jones, and that she reported that she was also having some sciatic problems and had been in therapy but was taken out due to her frequent falling. It was noted that Petitioner stated that she had EMG studies done showing no nerve damage in her back. The assessment was that of bilateral leg pain and weakness status post TKAs and pain in the left knee. It was noted that in light of the persistent symptoms, Dr. Davis recommended that she be scheduled for a bone scan, and that she use a cane for protected ambulation due to her recent fall history. Included within the records was a report for an EMG/Nerve Conduction Study performed on July 22, 2015, which was interpreted as revealing (1) mild bilateral peroneal neuropathy due to axonal loss; (2) no evidence of lumbar radiculopathy on either side. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by Dr. Jones on June 5, 2015 for complaints of lumbar spine pain. It was noted that Petitioner stated that the symptoms had been chronic non-traumatic, and that the symptoms occurred constantly. It was noted that the pain was described as aching and discomforting, and that the pain was located in the lower back and radiated to the foot on the left side. It was noted that Petitioner was still having significant leg pain but had not had a chance to have her spinal cord stimulator trial completed. It was noted that Petitioner had rather diffuse complaints in the leg which were non-dermatomal in nature and that Dr. Jones was not sure that any one level could cause all of the symptoms that were being seen. It was noted that it was possible that she had a damaged nerve root but that the pain pattern was not consistent with any single nerve root. It was noted that Dr. Jones thought a spinal cord stimulator trial was reasonable and that he did not think there was anything more to be offered surgically. It was noted that Petitioner was released and that any further off work notices would need to be handled by pain management or her primary care physician as they had no reason to keep her off work at that time. The assessment was that of degeneration of lumbosacral disc. A work slip was issued, indicating that Petitioner was to remain off work until July 1, 2015 when she was to be evaluated by Dr. Criste, and that further work status would be determined by her primary care physician or Dr. Criste. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on May 7, 2015 by Dr. Davis, at which time she complained of left knee pain and pain on the right side equally. It was noted that the symptoms were aggravated by ascending stairs, descending stairs and bending, and that in addition to left knee pain she was also experiencing tenderness, weakness and decreased mobility. It was noted that Petitioner stated that her symptoms were better than they were before surgery but she continued to have pain. The impression was that of improved but residual discomfort status post bilateral TKA. Petitioner was recommended to continue with home exercise program including aqua therapy. At the time of the April 16, 2015 visit with Dr. Jones, it was noted that Petitioner presented with complaints of lumbar spine pain. It was noted that the symptoms were severe, that the pain was described as discomforting and aching, and that the pain was located in the lower back and radiated to the left foot. It was noted that Petitioner had no relief after a lumbar epidural steroid injection with Dr. Criste and was still having left leg pain with heel pain. It was noted that Dr. Jones was concerned that Petitioner's leg symptoms may be from damage to the nerve since she did not respond to surgical decompression and did not seem to be improving with steroid medications. Petitioner was recommended to undergo an EMG of the bilateral lower extremities to assess for possible peripheral neuropathy, and she was recommended to follow-up with Dr. Criste for possible consideration of a spinal cord stimulator trial. The assessment was that of lumbago, pain in limb and abnormal skin sensitivity. A work status slip was issued indicating that Petitioner was unable to perform any work duties until re-evaluated. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by Dr. Jones on February 19, 2015, at which time it was noted that Petitioner's pain was located in the lower

back and radiated on the right and left sides equally then to the foot on the right side. It was noted that Petitioner reported numbness to the whole leg on the left side. It was noted that the MRI of the lumbar spine showed improvement in the lumbar disc herniation at the L4-5 level, and that there was some subtle lateral recess stenosis on the left which correlated with her continued leg paresthesias. It was noted that Dr. Jones did not recommend further decompression of the lateral recess until Petitioner had exhausted all conservative measures. The assessment was that of lumbago and lumbar radiculopathy. Petitioner was referred to Dr. Criste for a lumbar epidural steroid injection. A work slip was issued on that date, indicating that Petitioner was unable to perform any work duties until re-evaluated. At the time of the January 6, 2015 visit with physician's assistant Angela Arnold, it was noted that Petitioner presented to the clinic for low back pain with left foot numbness and cold after walking. It was noted that Petitioner was approximately fourth months' status post lumbar microdiscectomy and doing well, but she continued to have a modest degree of low back pain and left foot numbness. It was noted that Petitioner completed physical therapy with minimal improvement, and that she felt the symptoms were significantly affecting her activities of daily living. An MRI of the lumbar spine was to be obtained to ensure that she did not have a new disc herniation, and x-rays were to be obtained to assess her stability. The assessment was that of lumbago. A work slip was issued on that date, indicating that Petitioner was unable to perform any work duties until re-evaluated. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on November 4, 2014, at which time it was noted that she was having sharp pain in the lower back, left toe numbness and her heel was sore. Petitioner was instructed to start a Medrol Dosepak and start physical therapy. A work slip was also issued on November 5, 2014, indicating that Petitioner was unable to perform any work duties until re-evaluated. Included within the records were physical therapy notes for the timeframe of November 7, 2014 through January 5, 2015. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by Dr. Jones on July 31, 2014 for a consult. It was noted that Petitioner complained of low back pain with burning on the left side and left leg pain to the ankle with foot and toes numbness. It was noted that the onset was one month ago, and that Petitioner had not undergone any conservative treatment. It was noted that Petitioner was injured at work and had to have a bilateral knee replacement, and that during her rehabilitation from her knee surgeries she began having left buttock pain that radiated down the leg. It was noted that this had been going on for some time, approximately two months, and that she had some oral steroids without any significant relief. It was noted that Petitioner appeared to have some atrophy in the left calf as well as some plantar flexion weakness. It was noted that Petitioner had significant leg pain and was offered a microdiscectomy at L5/S1 to decompress the S1 nerve root as she was clearly starting to have some motor issues in the S1 distribution. A work slip was issued on that date, indicating that Petitioner was unable to perform any work duties until re-evaluated. At the time of the July 31, 2014 visit with Dr. Davis, it was noted that Petitioner complained of pain in the right and left knees equally, and that in addition to pain she was also experiencing decreased mobility, limping, night pain, nighttime awakening, stiffness and tenderness. It was noted that Petitioner stated that she had lost some motion in her knees due to back pain, and that she was being seen by Dr. Jones for a herniated disc and was being scheduled for surgery. It was noted that the assessment was that of slow progress status post bilateral TKA secondary to HNP. Petitioner was instructed to continue her home exercise program. Included within the records was the Operative Report from Herrin Hospital dated August 27, 2014 pertaining to an L5-S1 microdiskectomy. The pre- and post-operative diagnosis was that of L5-S1 disk herniation. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on September 11, 2014 by Dr. Jones, at which time it was noted that Petitioner was still having numbness in the left toes and was worse since surgery. At the time of the October 30, 2014 visit with Dr. Davis, it was noted that Petitioner was seen for follow-up of the bilateral TKA performed on March 4, 2014. It was

noted that Petitioner was complaining of intermittent, sharp knee pain. It was noted that Petitioner had a lumbar hemilaminectomy on August 27, 2014 and was having sciatic-type pain with numbness in her left foot. Petitioner was instructed to continue with the home exercise program and was also recommended to start aqua therapy. A work slip was issued on October 30, 2014 indicating that Petitioner may participate in modified duty and was to do no kneeling, squatting, limit stairs and lift no more than 10 pounds. Included within the records was an interpretive report for an MRI of the lumbar spine performed on July 17, 2014, which was interpreted as revealing (1) at L5/S1 there is a left paracentral disc extrusion measuring 0.9 x 1.1 x 1.8 cm, which fills the left lateral recess and likely compresses the descending left S1 nerve; (2) neural foraminal narrowing is moderate at L5/S1 bilaterally and mild to moderate at L4/L5 bilaterally; (3) disc dessication with mild disc height loss at L5/S1; (4) Baastrup's disease with abutment of the L3, L4 and L5 spinous processes. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by Dr. Davis on July 3, 2014 after bilateral total knee arthroplasties, reporting increased pain in the left leg with no provocation. It was noted that Petitioner had pain if she tried to extend the knee in certain positions, and that the pain radiated all the way up into her low back by her report. The assessment was that of low back pain with radiculopathy after total knee. An MRI of the lumbar spine was recommended. At the time of the June 4, 2014 visit with Dr. Davis, It was noted that Petitioner's bilateral knee pain occurred intermittently and was improving. It was noted that Petitioner stated that she was doing better, that she reported increased pain since she had not been in therapy and that she continued to have popping. It was noted that Petitioner was doing well status post bilateral TKA. Petitioner was instructed to continue with the home exercise program and restart therapy for strengthening. At the time of the May 27, 2014 visit with Dr. Davis, Petitioner reported that she was not having any physical pain and that her concern was that the knees "pop" equally. The impression was that of very slow progress after bilateral total knee arthroplasty. It was noted that Petitioner did not feel ready to return to normal work activity. Petitioner was instructed to continue physical therapy. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on April 28, 2014 by Dr. Davis in follow-up for the bilateral TKA. It was noted that Petitioner stated that she was doing well but reported that about three weeks ago therapy was increased to 30 pounds and ever since then she had had severe pain, and that since then therapy had "backed down." It was noted that Petitioner was having satisfactory progress and that was to continue with therapy but would avoid strengthening at that time. At the time of the January 23, 2014 visit with Dr. Davis, Petitioner presented to discuss the possibility of TKA. It was noted that Petitioner suffered from chronic knee pain due to arthritis, and that she stated that the pain in her left knee was more severe than the pain in the right knee. It was noted that Petitioner wanted to consider bilateral TKAs. It was noted that the working diagnosis and treatment options were discussed in detail with Petitioner and her daughter, and that Petitioner decided to proceed with TKA on the bilateral knees. A work slip was issued on January 9, 2014, indicating that Petitioner could participate in modified duty, beginning sedentary duties. A Nurse Note was included in the records dated December 27, 2013, indicating that Petitioner was given a message that she was going to have to see her family physician to get pain medications as Dr. Davis could not continue this strength of medications for this long without a plan for surgery, and that her pain would not be able to be controlled post-operatively as long as she was taking this much pre-operatively. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was issued a work slip on November 28, 2013 indicating that she was unable to work full duty but could work sedentary duty only. The September 5, 2013 evaluation note of Dr. Davis noted that Petitioner's chief complaint was that of left knee giving way and pain. It was noted that the onset was sudden from an injury which occurred at work on November 28, 2012. The assessment was that of osteoarthritis. It was noted that Petitioner had elected to proceed with surgical intervention in the form of a left total knee arthroplasty. A work slip was also issued on that date, allowing Petitioner to participate in sedentary duty. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by Dr. Davis on August 26, 2013, at which time it was noted that she was being seen in follow-up of her bilateral knee pain following a work injury being status post left knee arthroscopy and post-surgical physical therapy and viscosupplementation. It was noted that Petitioner stated that she had really gotten no relief from the viscosupplementation injections, was tired of living with her pain and felt like she had to get something done. It was noted that Petitioner stated she was really ready to get back to work and her lifestyle, but current could not even walk 100 yards without being in significant pain. It was noted that Petitioner had predominantly left knee pain, but she stated that her right knee was becoming essentially equal as she had continued to compensate. The assessment was that of status post left knee arthroscopy with residual arthritic aches and pains with severe medial compartment arthrosis along with compensatory right knee pain with underlying degenerative meniscal changes with moderate to early severe right knee osteoarthritis. It was noted that Petitioner was recommended to see a total joint specialist, Dr. Davis, and that she would discuss with him options of further treatment including knee arthroplasty. A work slip was issued on that date, allowing Petitioner to work sedentary duties only. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on July 22, 2013 following left knee arthroscopy and Supartz injections, still having significant pain that she could not tolerate. The assessment was that of bilateral knee osteoarthritis. Petitioner was given another month of home exercises and protective body mechanics. It was noted that if she failed to respond, she would be sent to Dr. Barr for a knee replacement consultation. A work slip was issued on that date, allowing Petitioner to work sedentary duties only. Included within the records was an interpretive report for an MRI of the right knee performed on July 15, 2013, which was interpreted as revealing discoid lateral meniscus with suggestion of tear involving its anterior horn; Grade 2 signal within the medial meniscus; increased signal intensity within the posterior cruciate ligament along its tibial attachment may be due to previous partial tear; small joint effusion. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on July 15, 2013 for follow-up of her left knee arthroscopy done on March 15, 2013. It was noted that Petitioner was undergoing Supartz to the left knee, and that she was having some right knee pain as well that had not improved to a corticosteroid shot that she had a couple of weeks ago. The assessment was that of bilateral knee osteoarthritis status post left knee arthroscopy. Petitioner was given an injection of Supartz on that date. It was noted that Petitioner failed to improve with activity modification and a corticosteroid injection into the right knee, and that an MRI would be requested to evaluate for underlying meniscal tearing. It was noted that it may have been exacerbated by her protective body mechanics of the left lower extremity following surgery with her persistent pain. A work slip was issued on that date, allowing Petitioner to work sedentary duties only. At the time of the July 8, 2013 visit, it was noted that Petitioner was having ongoing right knee pain as well as left knee pain. It was noted that it was getting progressively worse and that she had a corticosteroid shot that was not yet helping. The assessment was that of bilateral knee osteoarthritis status post left knee arthroscopy. Petitioner's left knee was injected with Supartz, and it was noted that she was going to return in a week for the third and final injection for the left knee and that they were going to monitor the right knee for another week. A work slip was issued on that date, allowing Petitioner to work sedentary duties only. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on July 1, 2013 to begin a series of three Supartz injections for her left knee osteoarthritis following primary knee arthroscopy. It was noted that Petitioner was having some compensatory right knee pain and was requesting a corticosteroid injection for that. It was noted that there was no change in her symptoms. The assessment was that of bilateral knee osteoarthritis status post left knee arthroscopy. Petitioner was given a Supartz injection in the left knee on that date. Petitioner was also given a Decadron injection in the right knee on that date. A work slip was issued on that date, allowing Petitioner to work sedentary duties only. A work slip was also issued on June 10, 2013, allowing Petitioner to work sedentary duties only.

At the time of the May 13, 2013 visit, it was noted that Petitioner stated she was making improvement with therapy over the past week especially, and that she was still achy and painful predominantly anteriorly. The assessment was that of progressing following left knee scope with partial medial meniscectomy and synovectomy on March 15, 2013 with improving left lower extremity weakness and peripatellar pain. Petitioner was given orders for another month of physical therapy, and it was noted that she would benefit from an anti-inflammatory. A work slip was issued on that date, allowing Petitioner to work sedentary duties only. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on April 15, 2013, at which time it was noted that she was better than she had been following arthroscopic partial medial meniscectomy on March 15, 2013. It was noted that Petitioner still had some pain on the peripatellar region with painful clicking around the patella, and that she had not done therapy to date. The assessment was that of progressing following left knee partial medial meniscectomy and synovectomy on March 15, 2013 with some left lower extremity muscle weakness and peripatellar pain. Petitioner was instructed to begin physical therapy. A work slip was issued on that date, allowing Petitioner to work sedentary duties only. At the time of the March 27, 2013 visit, Petitioner was complaining of pain and swelling in the leg. Petitioner was instructed to undergo labs and a Doppler to ensure there was no blood clot. A work slip was issued on that date, indicating Petitioner was unable to perform any work duties until re-evaluated. The Operative Report dated March 15, 2013 noted that Petitioner underwent (1) left knee arthroscopic partial medial meniscectomy; (2) left knee arthroscopic synovectomy; and (3) left knee injection of 8cc of 0.5% plain Marcaine and 2cc or 8mg of Decadron on that date for a pre-operative diagnosis of left knee medial meniscus tear and a post-operative diagnosis of left knee medial meniscus tear, synovitis. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on March 5, 2013 prior to her surgery for her left knee for persistent medially-based knee pain. The assessment was that of left knee medial meniscus tear and arthritis. A work slip was issued on that date, indicating that Petitioner was unable to work until re-evaluated 10-12 days post-operatively. A Nurse Note dated March 4, 2013 noted that Petitioner had called and was complaining of pain and swelling. It was noted that Petitioner's pain was so severe that she was not able to get out of bed and go to work, and that she was requesting an off work slip and prescription refill. It was noted that Petitioner was also requesting an off work note until her scheduled surgical procedure. Petitioner was scheduled for an appointment on March 5, 2013 for further evaluation. A work slip was issued on March 4, 2013, excusing Petitioner from work on March 4th and March 5th until further evaluation on March 5th. At the time of the January 23, 2013 visit, Petitioner presented with persistent deep pain within the knee predominantly anteromedially in nature. The assessment was that of 56-year-old female with left knee medial meniscus tear and underlying osteoarthritis. Surgery was discussed and Petitioner indicated her desire to proceed. A work slip was issued on that date, allowing Petitioner to continue working no restrictions. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on January 15, 2013 for an MRI of the left knee. The exam history noted pain. The report indicated that the MRI was interpreted as revealing (1) medial meniscus mid body small oblique tear extending to the inferior articular surface and measuring approximately 0.8 cm in length; (2) discoid lateral meniscus; (3) patellar tendinopathy, likely acute at its insertion; correlate with clinical symptoms. At the time of the consultation on January 9, 2013, it was noted that Petitioner presented with complaints of left knee pain that began at work on November 28, 2012 when she was carrying a box of paper across the building at work, squatted down, moved a couple of reams of paper and when she went to stand up, felt a pop and a sharp pain in the medial aspect of her knee. It was noted that Petitioner never had any complaints of the knee leading up to this. It was noted that Petitioner's pain was slightly improved since the injury but still was significantly limiting her ability to get about. It was noted that Petitioner had a predominantly desk-type job, and had to get up and down a lot to retrieve paperwork and move about the office. It was noted

that Petitioner had been able to tolerate that and continue her full work duty. It was noted that Petitioner had been taking Vicodin but had not had any other treatment yet. The assessment was that of a 56-year-old female with a left knee medial meniscus tear and mild underlying osteoarthrosis. An MRI was recommended. It was noted that if the MRI showed evidence of definite meniscal tearing Dr. Davis would likely recommend arthroscopic surgery to address it. Petitioner was allowed to continue her current full duty work status. (PX2).

The medical records of SIH Brain & Spine Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen for physical therapy on July 1, 2015, and she was referred to NovaCare of Benton. (PX3).

The records of SIH Brain & Spine Institute reflect that Petitioner was seen on July 1, 2015 for follow-up of low back pain, and it was noted that Petitioner wanted to discuss the spinal cord stimulator. It was noted that Petitioner had had injections which did not provide significant relief, and that she continued to be unable to work and was on disability. An EMG/NCV of the lower extremities was recommended, and Petitioner was sent to physical therapy for an FCE. It was noted that spinal cord stimulation was discussed and it was agreed that it would be best to hold off because she had done poorly with any implants in the past. (PX3).

The medical records of Memorial Hospital of Carbondale were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent bilateral total knee arthroplasties on March 4, 2014 for a pre- and post-operative diagnosis of osteoarthritis of the right knee and degenerative arthritis of the left knee, respectively. During Petitioner's admission, she was seen in consultation for post-operative medical management of uncontrolled hypertension with evaluation of the palpitations. The Rehabilitation Consultation dated March 5, 2014 noted that Petitioner had a history of bilateral knee pain for 16 months prior to the procedure which failed conservative treatments of injections and physical therapy. (PX4).

The medical records of Cape Neurosurgical Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on February 17, 2016 for follow-up of low back pain and right greater than left lower extremity radiculopathy. It was noted that since her last visit, Petitioner had had an injection by Dr. Keith right L5-S1 and had very minimal and temporary improvement. It was noted that Petitioner was continuing with therapy and felt that her strength was a little bit better. It was noted that Petitioner had also seen Dr. Gardner, whose greatest concern was that Petitioner essentially was having a spinal cord injury and neurologic symptoms likely from B12 deficiency. It was noted that Dr. Ray saw some disc bulging on the right side of L5-S1 which could be contributing to some of her complaints of pain but given all of the other neurologic signs, Dr. Gardner wanted to deal with that first. Petitioner was discharged to the care of Dr. Gardner. (PX5).

The records of Cape Neurosurgical Associates reflect that Petitioner was seen on December 18, 2015 for follow-up of low back pain and right greater than left lower extremity radiculopathy. It was noted that since her last visit on November 4, 2015, Petitioner had undergone an MRI of the cervical spine. It was noted that Dr. Ray did not see a significant compression, and that he did not see a reason for Hoffman's. It was noted that Petitioner was to see a neurologist because Dr. Ray did not have an explanation for her Hoffman's and wanted a second opinion. It was noted that the MRI of December 2, 2015 showed old residua on the left side at L5-S1 "probably that [was] not causing a significant part of her issue" but that when she saw neurology they could also address if they thought she was having a left radicular component. It was noted that on the right side, there was a foraminal disc that approached the L5 nerve root, and that the question was whether that could be causing a problem, so Dr. Ray wanted Petitioner to see neurology who could consider electrical studies. It was noted that Dr. Ray also wanted Petitioner to see pain management so that would have to be timed carefully and to see if they could work

out a non-surgical plan for the back and leg symptoms so Petitioner could avoid surgery. It was also noted that Dr. Ray would be introducing Petitioner to one of the spinal stimulation reps. (PX5).

The records of Cape Neurosurgical Associates reflect that Petitioner was seen on November 5, 2015, at which time it was noted that Petitioner had low back pain with right greater than left lower extremity radiculopathy in the right lower extremity, and that the right L5 lower extremity radiculopathy was newer in the last 4-6 weeks. It was noted that the residual symptoms in the left lower extremity went down the posterior and lateral aspect of the left lower extremity were chronic since her surgery in August of 2014. It was noted that Petitioner had hyperreflexia, and that Dr. Ray needed to rule out cervical myelopathy. It was noted that the MRI of the lumbar spine performed on October 9, 2015 showed possible residual disc and possibly synovial cyst left side of L5-S1 with questionable stenosis related to new disc herniation versus scar tissue. It was noted that on the right side of L5-S1 there was also lateral recess narrowing due to diffuse bulging as well as right L5 foraminal narrowing of moderate nature at L4-5, and that there was facetitis at both L4-5 and L5-S1 levels. Petitioner was recommended to undergo an MRI of the lumbar spine to better differentiate scar tissue versus new or extruded disc, as well as an MRI of the cervical spine given the hyperreflexia and more diffuse weakness in the lower extremities. Petitioner was also referred to the Pain Clinic for diagnostic and therapeutic injections. (PX5).

Included within the records of Cape Neurosurgical Associates was an interpretive report from Saint Francis Medical Center regarding an MRI of the cervical spine performed on December 2, 2015, which was interpreted as revealing (1) mild cervicothoracic dextroscoliosis; (2) small C6-C7 central disc protrusion; no cord deformity or central spinal canal stenosis; (3) minor multilevel degenerative spondylosis; mild multilevel facet hypertrophy; (4) irregular 2.5cm T2 hyperintense nodule within the right upper lobe of the right lung; a CT of the chest is recommended for further evaluation. The interpretive report for an MRI of the lumbar spine performed on the same date indicated (1) S1 is partially lumbarized on the right; (2) post-operative left L5-S1 hemilaminectomy changes with contrast enhancing epidural fibrosis along the left dorsolateral thecal sac and surrounding the left S1 nerve root; there is a small right L5-S1 paracentral disc protrusion which displaces the right S1 nerve root posteriorly; (3) minimal bilateral L4-L5 and right greater than left L5-S1 foraminal stenosis; (4) no significant central spinal canal stenosis; (5) lower lumbar facet hypertrophy. The interpretive report for a CT of the lumbar spine performed on the same date indicated (1) the findings are generally consistent with those reported in the previous MRI examination; (2) there is modest straightening of the lumbar lordosis; vertebral body heights and alignment are well maintained; there are modest degenerative changes in the disc endplates with mild reduction in disc height and vacuum disc phenomenon noted L5-S1; (3) the central canal remains adequate patent at all reviewed levels; (4) the neuroforamina are generally patent with the exception of L5-S1 where there is mild stenosis associated with modest disc bulge and disc/osteophyte intrusion; the patient has had a decompressive left hemilaminectomy at this level. (PX5).

The medical records of Neurologic Associates of Cape Girardeau were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on February 4, 2016 for consultation regarding her back pain. It was noted that Petitioner indicated that she was injured causing significant back pain with a herniated disk, that she underwent a microdiskectomy and had transient improvement for about a week with subsequent recurrence of pain. It was noted that the pain in the back radiated down both legs, more on the right than the left, and that at times her legs buckle underneath her. It was noted that, per Dr. Gardner, Petitioner appeared myelopathic, and that he wondered if she was B12 deficient with subacute combined myeloneuropathy. Petitioner was to undergo blood work and an MRI of the thoracic spine "since the region had not been imaged." It was noted that Petitioner had upper extremity hyperreflexia which could not be explained by a thoracic lesion, so an MRI of the brain would be sought to evaluate for conditions like MS. It was noted that a panel of labs would be sent as well, and that an EMG of both lower extremities would be obtained to evaluate for the neuropathy history as well as to look for active radiculopathy that might be amenable to further

decompression. Included within the records was a Clinical Electromyography Report dated March 1, 2016, which indicated that the study provided electrodiagnostic evidence for mild chronic denervation in the bilateral L5 distribution; no active denervation was seen in either lower extremity to suggest acute radiculopathy; mild asymmetry in the tibial nerve CMAP amplitudes may be related to the underlying lumbosacral radiculopathy, as there was no asymmetry in sural SNAP amplitudes; no convincing evidence for large-fiber peripheral neuropathy. (PX6).

The records of Neurologic Associates of Cape Girardeau reflect that Petitioner was seen on March 1, 2015, at which time the laboratory studies were reviewed. It was noted that Petitioner stated that she had had significant improvement in her spasms and parethesias since starting on a multivitamin and B12 injections. It was noted that an MRI of the thoracic spine and brain were obtained and did not reveal structural cause for the spasticity. It was noted that given Petitioner's improvement, additional evaluation would not be pursued. At the time of the May 31, 2016 visit, it was noted that Petitioner was seen in follow-up of B12 deficiency, memory impairment and myelopathy. It was noted that Dr. Ray was reluctant to consider additional operative intervention given the degree of epidural fibrosis, and that Petitioner was working with Dr. Keith for pain management with some improvement. It was noted that Dr. Gardner though Petitioner had disability related to her back pain and it was noted that she was planning early retirement later that month. It was noted that Petitioner would be seen in another month, but she should not work until that time. (PX6).

The records of Neurologic Associates of Cape Girardeau reflect that Petitioner was seen on June 27, 2016, at which time it was noted that Petitioner's myelopathy was stable and that her B12 levels were within range. It was noted that Petitioner indicated that she recently lost her primary care physician and requested that Dr. Gardner refill her medications until she could obtain an appointment in July. It was noted that Petitioner's pain medications were managed by Dr. Keith. Included within the records was an interpretive report for an MRI of the brain performed on February 23, 2016 at Southeast Hospital, which was interpreted as revealing no acute infarct, mass or hemorrhage; minimal non-specific-appearing while matter lesions most consistent with microvascular disease. The interpretive report for an MRI of the thoracic spine performed on the same date indicted an impression of unremarkable magnetic resonance imaging of the thoracic spine; no evidence for cord compression, mass lesion or intraaxial thoracic spinal cord lesion. (PX6).

The medical records of NovaCare were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent an FCE on August 6, 2015, at which time it was noted that she did not demonstrate the ability to complete the job of a Case Worker based on the job description provided by the patient. It was noted that the physical demand level was that of Medium, and that deficits identified during testing included walking more than occasional basis due to left toe drag, inability to balance on unlevel surfaces and ladders and the inability to perform crouching and kneeling, and that she was unable to safely lift materials off of the floor due to knee flexion limitation and lumbar limitation. It was noted that Petitioner was also limited in her ability to perform stairs as she was unable to descend reciprocally. It was noted that Petitioner had consistent test performance. (PX7).

The medical records of SIMCA were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on September 15, 2016, at which time she was seen to establish care with Dr. Burge. It was noted that Petitioner was having some medication issues, and had complaints of weakness and fatigue. It was noted that Petitioner was being followed by pain management for neck and back pain, and that she had pseudotumor cerebri for which she was being followed by neurology. The assessment was that of GERD, dysphagia, lesion of lung, chest pain and benign intracranial hypertension. At the time of the February 16, 2016 visit, Petitioner was seen in follow-up. It was noted that Petitioner had started seeing a new neurosurgeon for her back and had been recommended to have a "cage from L3-L5." It was noted that Petitioner continued to have episodic weakness and would fall at times, and that she saw a new neurologist and had started a work-up in regards

to her weakness. The assessment was that of degeneration of lumbar intervertebral disc, neuropathy and muscle weakness. (PX8).

The records of SIMCA reflect that Petitioner was seen on September 17, 2015 for a pre-operative evaluation for an eyebrow lift for ptosis. It was noted that Petitioner had chronic pain in the knees and lower back but it was tolerable with her current medications. Petitioner was cleared to proceed. At the time of the July 29, 2015 visit, Petitioner presented for a review of medications. It was noted that Petitioner had sorted out issues regarding worker's compensation paperwork with Dr. Jones and Criste, and that she had been off all medications prior to having nerve conduction studies. It was noted that Petitioner had weakness in the left foot and leg, and that she was having falls four times per week on average. It was noted that Petitioner's back pain was persistent and had worsened significantly without using Butrans. The assessment was that of low back pain, benign intracranial hypertension, anxiety and depressive disorder. (PX8).

The records of SIMCA reflect that Petitioner was seen on May 11, 2015 with complaints of flu-like symptoms after epidural injections. It was noted that Petitioner's husband stated that was slurring her words a little and that her gait was off. It was noted that Petitioner was considering a spinal stimulator and was to return to pain management soon, and that she had not seen any improvement with Celebrex. The assessment was that of lumbago and cellulitis. It was noted that Petitioner would try Butrans for her chronic back issues. At the time of the April 10, 2015 visit, Petitioner was seen in follow-up and it was noted that Petitioner's headaches were worsening. The assessment was that of headache, hypertensive disorder, obesity and benign intracranial hypertension. At the time of the February 13, 2015 visit, it was noted that Petitioner was having headaches, among other issues. (PX8).

The records of SIMCA reflect that Petitioner was seen on January 15, 2015 to re-establish care. It was noted that Petitioner had a history of anxiety and depression and was not currently on any chronic medication. It was noted that Petitioner had a history of arthritis and back and knee pain, and that she underwent bilateral TKA and disc surgery by Dr. Jones. It was noted that Petitioner would start on Celebrex for chronic arthritic issues. (PX8).

The medical records of Southern Illinois Healthcare/Rehabilitation Institute of Chicago were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on January 7, 2016 for knee pain. The assessment was that of lumbosacral radiculopathy; deconditioned low back; status post bilateral knee replacements; peripheral neuropathy; and essential hypertension, among others. (PX9).

The transcript of the deposition of Dr. Jeffrey Jones was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. Dr. Jones testified that he is a board-certified neurosurgeon. He testified that he first saw Petitioner on July 31, 2014 because she was having problems after having bilateral knee replacements. He testified that Petitioner started having left buttock pain that radiated down the leg, and that an MRI showed disc herniation at L5-S1. He testified that when he saw Petitioner, she was starting to get some atrophy and weakness in her calf, which went along with compression of S1. He testified that his impression was that it was an S1 radiculopathy from the herniated disc and, given her weakness and atrophy, Petitioner was offered surgery. He testified that surgery was performed in August, which was an L5-S1 hemilaminectomy/microdiscectomy. (PX10).

Dr. Jones testified that at the time of the September 11, 2014 visit, Petitioner's numbness was a little worse, which was not uncommon for the first post-operative visit. He testified that at the November 4, 2014 visit, she was still having numbness and her heel was sore, but this was not surprising because she had wasting there. He testified that at the January 6, 2015 visit, Petitioner was still having numbness and he ordered an MRI to make sure she did not have a disc reherniation. He testified that after the second

MRI was performed, they were going to get injections to see if that helped at all. He testified that he last saw Petitioner on February 19, 2015. (PX10).

Dr. Jones testified that Petitioner's back pain evidently started after she had the bilateral knee replacements, and that with knee replacements you have to use your back more than you normally do. He testified that if there was a causal relationship, it was through the fact that Petitioner could not really bend over because of her knees and ended up not using good lifting mechanics. He testified that there was probably a causal relationship, and that it was not direct but was collateral damage from the bilateral knees. He testified that you did not have to have a major trauma for a disc herniation. When asked if he had an opinion whether or not the condition for which he was treating was a continuation of care stemming from the total knee replacements, Dr. Jones responded that it was probably related but "I don't know if causally, but at least because of the bilateral knees she had to do more bending at the back" which put her at more risk for herniating a disc. (PX10).

On cross examination, Dr. Jones testified that based on the MRI from July of 2014, he could not say when the disc extruded nor could he tell based on the surgery performed when the disc extruded. He testified that they were basing her timing off of when her symptoms began, and that usually symptoms would occur within 24-48 hours of herniating the disc because it took that long for the inflammatory process to start unless it was a direct compression of the nerve root itself, which would start right away. He testified that Petitioner indicated on the intake questionnaire that it started hurting more than normal and had been uncomfortable since meniscus tear from limping. He testified that he did not know when Petitioner had a meniscus tear that caused her to limp. (PX10).

On cross examination, Dr. Jones testified that it was the leg pain and atrophy that led him to offer surgery, and admitted that Petitioner could have just been trying to relate it to her worker's compensation claim. He agreed that sometimes patients can herniate a disc by simply coughing or sneezing. He testified that Petitioner probably bent over and blew out the disc bending over, but agreed that he indicated "probably" because he did not know what happened in this case. He testified that Petitioner could have done this before she had the bilateral knees. He testified that it was most likely that the atrophy was coming from the disc extrusion because Petitioner had pain in the buttock. (PX10).

On cross examination, Dr. Jones testified that persons in the obese category (like Petitioner) have low back problems. He testified that given her obesity and her disc bulges in the back, Petitioner could have had the disc extrusion bending over regardless of the bilateral knee replacement. (PX10).

On redirect examination when shown the July 3, 2014 note of Dr. Davis, he agreed that the visit with Dr. Davis established a beginning of the problem for Petitioner. He testified that he believed that the bilateral knees basically put Petitioner at a greater risk of herniating a disc. (PX10).

The transcript of the deposition of Dr. Mike Davis was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Dr. Davis testified that he is a board-certified general orthopedist but his practice is primarily knees including arthroplasty and arthroscopy. He testified that Petitioner was first seen for treatment at the clinic related to the left knee on January 9, 2013, and that her chief complaint was that of left knee pain. He testified that, according to the medical records, Petitioner reported that on November 28, 2012 she was carrying a box of paper across her building at work, she squatted down to move some of the reams of paper and that when she went to stand up, she felt a pop and sharp pain on the inside of her knee. He testified that Dr. J.T. Davis's impression on that date was that of left medial meniscal tear with underlying osteoarthritis, and that he recommended an MRI. (PX11).

Dr. Davis testified that the MRI obtained January 15, 2013 was interpreted as revealing a medial meniscal tear almost a centimeter in length as well as a discoid lateral meniscus. He testified that Dr. J.T. Davis discussed with Petitioner about doing an arthroscopic procedure, that she chose to go forward and

that surgery was performed on March 15, 2013. He testified that it appeared that Petitioner's post-operative visits were unremarkable for any post-operative complications, but she continued to have problems. He testified that his first evaluation of Petitioner was performed on September 5, 2013. He testified that leading up to his care, Dr. J.T. Davis had prescribed some Synvisc injections which did not provide lasting relief. He agreed that July 1, 2013 was the first time that Petitioner began to complain of right knee pain as well as left knee pain. He testified that his use of the term "compensatory" pain would mean that in compensating for left knee symptoms, she was putting more demands on her right knee. (PX11).

Dr. Davis testified that he had no recordings in the chart or in the patient questionnaire that Petitioner ever complained or stated that she had any problems prior to her November 2012 work accident of having any knee pain on the right or left side. He testified that Dr. J.T. Davis also recommended an MRI of the right knee, which was performed on July 15, 2013. He testified that Petitioner, when asked how the pain started, indicated on the MRI questionnaire that she had a torn meniscus on the left side and that severe limping had caused the right knee to hurt. He testified that the MRI of the right knee was interpreted as revealing a discoid lateral meniscus with a suggestion of tear at the anterior horn and Grade 2 signal in the medial meniscus. He testified that in the July 22, 2013 note, Dr. J.T. Davis explained Petitioner's restrictions. (PX11).

Dr. Davis testified that his initial impression after the consultation on September 15, 2013 was that of osteoarthritis of the left knee, they discussed treatment options and Petitioner elected to proceed with a total knee arthroplasty in the left knee. He testified that Dr. J.T. Davis did not do total knee replacements, and that was why she was referred to him for evaluation. He testified that Petitioner had not yet had the knee replacements done, but that it was his recommendation that those were the next step in her course of treatment. He testified that Petitioner was seen for a follow-up visit approximately three months later on January 23, 2014, and that at that time she was continuing to complain of pain in both knees but the left was more severe than the right. He testified that through the end of Dr. J.T. Davis's care and into his, Petitioner's work restrictions continued. (PX11).

Dr. Davis testified that it was his opinion that the arthritis within Petitioner's knees was not caused by her work activities. He testified that he depended more on the regular x-rays to assess the amount of osteoarthritis, and that there was found to be a significant amount of joint space narrowing to justify total knee arthroplasty. He testified that osteoarthritic findings on x-ray did not directly correlate with symptomatic findings, so that someone who has that condition can function, work, live and do activities without pain. He testified that Petitioner claimed to have been asymptomatic prior to having the work injury in November of 2012. He testified that based on Petitioner's history afforded from the medical records, it appeared that a pre-existing osteoarthritic knee became symptomatic or became more symptomatic after her work-related injury. He testified that he believed the accident played a contributing role in the acceleration of her symptoms and agreed that he would relate the need for the medical treatment that she received after that activity to be related to her work-related injury. (PX11).

Dr. Davis testified that Dr. J.T. Davis removed the abnormal meniscus in the original arthroscopy, and that it was most likely a degenerative situation. He testified that it was his opinion that Petitioner's sudden onset of symptoms was most likely an extension or new tear through an abnormal pre-existing degenerative meniscus. He testified that it was his opinion that the work injury most likely accelerated the timeframe of eventual arthroplasty. He testified that it was most likely inevitable that at some point Petitioner was going to need knee replacement bilaterally in her life and that from the review of her radiographs it was probably within a matter of years, but that he felt like the work injury accelerated the need for that procedure bilaterally. He testified that he agreed, to some degree, that Petitioner's altered gait or limping had symptomatically caused the problems in her right knee. (PX11).

On cross examination, Dr. Davis agreed that he saw Petitioner on two dates. He testified that the x-rays taken by Dr. J. T. Davis in January of 2013 were of the left knee. He agreed that the x-rays showed osteoarthritis in Petitioner's knee and that it was close to end-stage at that point. He agreed that the accident that Petitioner complained of in 2012 did not cause her osteoarthritis, and that he could not attribute anything from the accident to the findings on the January 2013 x-rays of the left knee. He testified that some of the risk factors that caused people to develop osteoarthritis in the knees included patient habitus or weight, muscle strength, daily demands and family history to some degree. He testified that there was an increased risk factor for an individual with a BMI over 30. (PX11).

On cross examination, Dr. Davis testified that the first x-rays of the right knee that he reviewed were dated August 26, 2013 and that they demonstrated degenerative changes, especially on the medial aspect of the knees bilaterally. He testified that it would not be uncommon for a person age 56 with a BMI over 30 to have degenerative changes in both of their knees. He testified that it was his opinion that the radiographic changes noted in August of 2013 would most likely have been evident to a significant degree had they x-rayed the other knee earlier, and he agreed that they were longstanding. (PX11).

On cross examination, Dr. Davis agreed that the incident in November of 2012 was that she raised up without any load and felt her knee pop. He testified that a meniscus tear can be a twisting injury, but that also in the back part of the posterior aspect of the meniscus, in squatting the majority of the load of the body was on the posterior part so it was not uncommon. He agreed that people can hear popping in their knees and not have any damage in their knees. He testified that based on Petitioner's history, she had some sort of traumatic event to an abnormal meniscus and that there was no way with that amount of arthritic changes that the meniscus could be normal. He testified that it would be impossible to say with certainty whether she tore through an abnormal meniscus or extended a pre-existing tear. (PX11).

On cross examination, Dr. Davis agreed that people with advanced osteoarthritis degenerative changes in their knees typically had waxing and waning of their symptoms, and testified that the records from her initial consultation indicated that Petitioner reported that she did not have any waxing and waning. He testified that if Petitioner did have previous problems it would change his opinion to some degree, and that he would not be surprised if she had intermittent symptoms. He agreed that his relating Petitioner's need for treatment to the work-related injury was significantly based on her subjective history. When asked if he related the right knee to the work-related injury based on her saying that the right knee got worse, Dr. Davis responded that he based the exacerbation of her subjective symptoms to her altered gait, limping, favoring and putting more stress on the other knee. (PX11).

On redirect examination, Dr. Davis testified that Petitioner was in the process of post-arthroplasty physical therapy and had only one doctor visit with his physician's assistant. (PX11).

The Medical Bills Summary was entered into evidence at the time of arbitration as Petitioner's Exhibit 12.

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

The IME report of Dr. Richard Lehman was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The transcript of the deposition of Dr. Richard Lehman was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

Dr. Lehman testified that he is an orthopedic surgeon and is board-certified in orthopedic surgery with a subqualification in sports medicine. He testified that he performed an IME on December 3, 2013, at which time Petitioner reported that she was carrying a box of paper across the building she was

working in, squatted down and put the box down, and that when she went to stand up after moving two boxes, she felt a pop in her left knee. He testified that when he saw Petitioner, her complaints were primarily left knee pain and discomfort. He testified that Petitioner did not have any right knee complaints at that time, and that when he asked her what was bothering her, Petitioner told him that it was her left knee. (RX3).

Dr. Lehman testified that x-rays performed on the date of the IME showed severe degenerative changes bilaterally, primarily medial, somewhat in the patellofemoral joint, and complete obliteration of the joint space. He testified that the findings that were shown on December 3, 2013 pre-existed the November 2012 accident. He testified that he also reviewed an MRI of the right knee performed on July 15, 2013, which showed some degenerative changes in the knee. (RX3).

Dr. Lehman testified that Petitioner's diagnosis as of December of 2013 was that of bilateral end-stage degenerative arthritis of her right and left knees based on the examination performed, the x-rays taken, watching her walk and manually examining her knees. He testified that Petitioner's end-stage degenerative arthritis in her left knee was unrelated to her incident of November 28, 2012, and that he did not believe the incident exacerbated, altered or in any way changed the underlying process as it related to her knee. He testified that he did not believe that the fact that Petitioner injured her left knee in the case affected her right knee, and indicated that Petitioner had exact same pattern in both knees and did not believe that her right knee was in any way altered. He testified that any treatment that she had for her end-stage degenerative arthritis in both knees would not be related to the work accident of November 2012. (RX3).

Dr. Lehman testified that he gave an AMA rating with regards to the November of 2012 injury of 0% impairment because her condition was not related to the November 2012 accident. He testified that Petitioner had some limitations from her end-stage arthritis, but that the end-stage arthritis was not related to her work condition. He testified that the surgery performed on March 15, 2013 (*i.e.*, the medial meniscectomy) was not related to the November 2012 injury, as there was nothing identified either on the MRI or arthroscopically that would suggest that there was an acute or anatomical process temporal to the November 28, 2012 timeframe. (RX3).

Dr. Lehman testified that in the history that Petitioner gave him was that she stated that she squatted down, put the box down, stood up and had a pop in her knee. He testified that if Petitioner had had a significant load in her knee and had some type of rotational torque or rotational movement of her knee then that would stress the meniscus, but just the fact that she squatted down and stood up should not stress the meniscus. (RX3).

The IME Report of Dr. Joseph Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The transcript of the deposition of Dr. Joseph Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

Dr. Williams testified that he is an orthopedic surgeon and is board-certified in orthopedic surgery. He testified that 70% of his practice is devoted to spine-related issues, while 30% of his practice is general orthopedics. He testified that he performed an IME on January 25, 2016. He testified that Petitioner reported carrying a box of copier paper across her office space and then setting down the box at the copy machine. He testified that Petitioner stated that when she went to stand upright, she felt and heard a loud, audible pop in her left knee and that it was so loud her co-workers could hear it. He testified that when he saw Petitioner, she complained of low back pain that started approximately May of 2014. (RX5).

Dr. Williams testified that during the performance of the examination, he felt that Petitioner did not provide a great deal of cooperation with the physical exam in regards to the strength testing of her

lower extremities. He testified that Petitioner was refusing at times and stated that she was not able to dorsiflex the ankle whatsoever, and that she did not provide any extensor hallucis longus activation on the left. He testified that Petitioner voluntarily stood during the encounter and stated that she was unable to pick up her foot off the floor, and she would have to do so by flexing her knee and flexing the hip. He testified that he then asked her to walk around the examination room on her heels and she was actually able to bring the forefoot off the floor, which was contradictory. He testified that he felt that there was symptom magnification. (RX5).

Dr. Williams testified that her diagnosis was that of multilevel degenerative disc disease, which was something that took years to develop. He testified that Petitioner's morbid obesity was a risk factor for the development of degenerative disc disease, as was her age. He testified that he did not feel that Petitioner's lumbar spine condition was not related to her alleged work injury of November 28, 2012, and that he did not believe her condition was related to her bilateral knee replacements. He testified that he was not aware of any study that suggested or had correlated a finding between knee replacement and low back pain, and that it was very common to have severe arthritis develop in the knees with morbid obesity. He testified that he did not believe that the alleged work injury aggravated or accelerated Petitioner's lumbar spine condition, and that any activity of daily living could accelerate or cause a temporary exacerbation of a degenerative condition. (RX5).

Dr. Williams testified that he believed that Petitioner was at maximum medical improvement, and that further treatment could include weight loss, non-steroidal anti-inflammatory medications and an exercise regimen. He testified that he believed that Petitioner could work full duty without restrictions. (RX5).

The Denial Letter was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Settlement Contract for 06 WC 28871 was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The contract referenced an alleged accident of June 13, 2006 involving moving a box with the left leg, and that the nature of the injury was that of "7.5% of a left leg." The contract was approved on June 13, 2008. (RX7).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being in the left knee is causally related to the accident of November 28, 2012, but that she has failed to meet her burden of proving that her current condition of ill-being in the right knee and lumbar spine is causally related to the accident of November 28, 2012.

As it pertains to causation involving the left knee, having considered and reviewed the entirety of the medical evidence in the case, the Arbitrator places greater reliance upon the opinions of Dr. Davis in this case rather than those as proffered by Dr. Lehman, the Section 12 IME physician, as it pertains to causation involving the left knee. The Arbitrator notes that the accident reports entered into evidence at the time of arbitration as Respondent's Exhibit 1 and the medical evidence in this case reflect timely complaints of pain and treatment for issues involving the left knee after the accident which Respondent stipulated arose out of and in the course of her employment. (AX1). The Arbitrator notes that the medical records in this case demonstrate a lack of progression towards resolution of Petitioner's ongoing left knee symptomatology after the arthroscopy was performed on March 15, 2013 and, as a result, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being in the left knee is causally related to her accident of November 28, 2012.

As it pertains to causation involving the right knee, the Arbitrator is admittedly troubled by the inconsistencies in the medical records as to the purported onset and reporting of symptomatology and, as a result, finds that Petitioner has failed to meet her burden of proving that her current condition of ill-being in the right knee is causally related to the accident of November 28, 2012.

The Arbitrator notes that the records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on July 1, 2013 to begin a series of three Supartz injections for her left knee osteoarthritis following primary knee arthroscopy. At that time, it was noted that Petitioner was having some compensatory right knee pain and was requesting a corticosteroid injection (PX2). At the time of the September 5, 2013 visit with Dr. Davis, which was approximately two months later, he noted that Petitioner's chief complaint was that of left knee giving way and pain and it was noted that Petitioner had elected to proceed with surgical intervention in the form of a left total knee arthroplasty. (PX2). Approximately three months later, Petitioner was seen for a Section 12 examination with Dr. Lehman, who testified that when he saw Petitioner on December 3, 2013, her complaints were primarily left knee pain and discomfort, that she did not have any right knee complaints at that time, and that when he asked her what was bothering her, she told him that it was her left knee. (RX3). Some six weeks later, however, Petitioner was seen again by Dr. Davis to discuss the possibility of TKA. It was noted at that time that Petitioner suffered from chronic knee pain due to arthritis, and that she stated that the pain in her left knee was more severe than the pain in the right knee and that Petitioner wanted to consider bilateral TKAs. (PX2). The Arbitrator finds it to be incredulous that Petitioner would go from having no complaints of right knee pain at the time of the examination with Dr. Lehman to reporting pain severe enough in the right knee – only six weeks later -- with Dr. Davis so as to contemplate undergoing a right TKA. In light of Dr. Davis's testimony that it was most likely inevitable that at some point Petitioner was going to need bilateral knee replacements in her life and that from the review of her radiographs it was probably within a matter of years and his relating Petitioner's need for treatment to the work-related injury having been significantly based on her subjective history, the Arbitrator finds that Petitioner has failed to meet her burden of proving that her current condition of ill-being in the right knee is causally related to the accident of November 28, 2012.

As it pertains to causation involving the lumbar spine, the Arbitrator finds that Petitioner has also failed to meet her burden of proving that her current condition of ill-being in the lumbar spine is causally related to the accident of November 28, 2012.

The Arbitrator is perturbed by the reference in the medical records that at the time of the June 5, 2015 visit with Dr. Jones, he noted that Petitioner had rather diffuse complaints in the leg which were non-dermatomal in nature and that he was not sure that any one level could cause all of the symptoms that were being seen. (PX2). This notation, when coupled with the testimony of Dr. Williams that during the performance of the Section 12 examination on January 25, 2016, he felt that Petitioner did not provide a great deal of cooperation with the physical exam in regards to the strength testing of her lower extremities and that he felt that there was symptom magnification, admittedly causes the Arbitrator great consternation. Furthermore, the Arbitrator notes that even Dr. Jones when rendering his causation opinion for the lumbar spine admitted that if there was a causal relationship, it was through the fact that Petitioner could not really bend over because of her knees and ended up not using good lifting mechanics, that there was "probably" a causal relationship, and that it was not direct but was collateral damage from the bilateral knees. (PX10). In light of the foregoing, the Arbitrator finds that Petitioner has failed to meet her burden of proving that her current condition of ill-being in the lumbar spine is causally related to the accident of November 28, 2012.

With respect to disputed issue (J) pertaining to medical services, the Arbitrator notes that the medical bill summary in Petitioner's Exhibit 12 alleges outstanding medical bills of $3,246.04. (PX12).

Upon close scrutiny of the summary, the Arbitrator notes that Petitioner seeks the payment of various medical bills at Benton Community Healthcare for dates of service of May 2, 2014, June 23, 2014, July 1, 2015 and December 5, 2012, respectively. (PX12). The Arbitrator notes that the office visits at Benton Community Healthcare for the dates of service of May 2, 2014 and June 23, 2014 were for issues wholly unrelated to the underlying claim (*i.e.*, sinusitis and abdominal pain). (PX1). As a result thereof, Petitioner's request for the award of these particular medical bills is denied.

As to the visit at Benton Community Healthcare for the date of service of July 1, 2015, the Arbitrator notes that no corresponding medical records were provided for such date of service at this provider. (PX1). As the Arbitrator declines to speculate as to the basis for such visit, Petitioner's request for payment of such medical bill is denied.

As to the visit at Benton Community Healthcare for the date of service of December 5, 2012, the Arbitrator notes that the corresponding medical records for this particular date of service referenced initial post-accident treatment involving the left knee. (PX1). As a result thereof, the Arbitrator orders Respondent to pay the billing for this particular date of service.

As to the visit for the date of service of December 13, 2013 at Cape Radiology, the Arbitrator notes that no corresponding medical records were provided for such date of service by any provider, let alone Cape Radiology. As the Arbitrator declines to speculate as to the basis for such visit, Petitioner's request for payment of such medical bill is denied.

As to the visit for the date of service of November 12, 2015 at Memorial Hospital of Carbondale, the Arbitrator notes that the billing pertains to the nuclear medicine bone scan performed on that date. As the History referenced issues with the bilateral knees, the Arbitrator orders Respondent to pay the billing for this particular date of service in light of the Arbitrator's findings as to causation pertaining to the left knee.

In sum, the Arbitrator finds that Respondent shall pay the bills for the dates of service of December 5, 2012 at Benton Community Healthcare and November 12, 2015 at Memorial Hospital of Carbondale as contained in Petitioner's Exhibit 12, 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 originally sought the award of temporary total disability benefits for the timeframe of November 29, 2012 through May 31, 2016, but this was later modified to the timeframe of from March 9, 2013 through May 31, 2016 after witness testimony was completed. (AX1; Tran. 35).

The Arbitrator notes that Petitioner testified that she worked until about a week or so before she underwent the left knee arthroscopy, that the arthroscopy surgery was performed on March 15, 2013 and that Petitioner testified that after the scope she never returned to work after the scope with the exception of one unidentified day in light of her concern about potential discharge. The Arbitrator notes that Petitioner testified that she voluntarily resigned on May 31, 2016. After consideration of the totality of the medical evidence in this case including the various work slips provided by the various treating physicians, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 85 6/7 weeks, addressing the timeframe of March 9, 2013 through October 30, 2014, as October 30, 2014 was the first date on which Dr. Davis allowed Petitioner to participate in modified duty subsequent to the bilateral TKA procedure performed on March 4, 2014. (PX2).

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 an AMA rating was offered by Respondent of 0% impairment, but the Arbitrator notes that Dr. Lehman was of the position that such impairment was given in light of his opinion that Petitioner's condition was not related to the November 2012 accident. (RX3). The Arbitrator places lesser 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 voluntary retired on May 31, 2016. 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 56 years old on her date of accident. Given the age of Petitioner, 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 her work injury, Petitioner did not return to her pre-accident employment with Respondent as she voluntarily retired on May 31, 2016. 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 both of her knees hurt, that she was still going to pain management and a neurologist, that she was not able to return to work and that she retired voluntarily on May 31, 2016 because she did not think she could do the job anymore. The Arbitrator notes that the treatment records most temporally related to the arbitration hearing reflect that she was seen for a multitude of complaints, including back and lower extremity complaints, B12 deficiency and memory impairment, among others. (See, *e.g.*, February 5, 2016 note of Dr. Davis as contained in PX2; February 17, 2016 note of Dr. Ray as contained in PX5; May 31, 2016 note of Dr. Gardner as contained in PX6). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and limitations as it pertains to the left knee, were somewhat corroborated by her treating records at the conclusion of her treatment. 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 **40% loss of use of the left leg** under Section (e) of the Act. Related thereto, Respondent is entitled to a credit of 7.5% loss of use of the left leg in light of the prior settlement on the same body part as set forth in the Settlement Contract Lump Sum Petition and Order in 06 WC 28871, *Sharon Ragland v. Pinckneyville Correctional Center*.

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

Arturo Sandoval,

Petitioner,

vs. NO: 09 WC 34917

Advanced Restoration, LLC, Jason Wiltfang, and Illinois State Treasurer as Custodian of the Injured Workers' Benefit Fund,

18IWCC0320

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Illinois State Treasurer as Custodian of the Injured Workers' Benefit Fund ("IWBF") herein and notice given to all parties, the Commission, after considering the issues of nature and extent and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

After closely reviewing the totality of the evidence, the Commission finds the Arbitrator's award of 75% loss of use of the person as a whole is appropriate in light of the evidence of Petitioner's injuries, extensive medical treatment, and complaints of significant chronic pain. However, the Commission modifies the Arbitrator's award of penalties and fees. The Arbitrator ordered Respondents to pay penalties pursuant to §19(k) of the Act in the amount of $67,688.99. The Arbitrator ordered Respondents to pay fees pursuant to §16 of the Act in the amount of $27,075.59. The Arbitrator also ordered Respondents to pay penalties pursuant to §19(l) of the Act in the amount of $10,000.00. For the reasons set forth below, the Commission modifies the Arbitrator's Decision by ordering only Respondents Advanced Restoration, LLC and Jason Wiltfang to pay the penalties and fees.

Respondent IWBF did not dispute the Arbitrator's conclusion that the employers' failure

18IWCC0320

to provide any workers' compensation benefits to Petitioner was vexatious and unreasonable. Respondent IWBF also did not dispute the amount of penalty and fees awarded by the Arbitrator as a result of the employers' unreasonable behavior. Instead, Respondent IWBF took exception to the Arbitrator's order that all Respondents pay the assessed penalties and fees. After considering this issue, the Commission finds Respondent IWBF is not liable for any assessed penalties and fees.

Section 4(d) of the Act states in relevant part, "Moneys in the Injured Workers' Benefit Fund shall be used only for payment of workers' compensation benefits for injured employees when the employer has failed to provide coverage...and has failed to pay the benefits due to the injured employee." It appears no Illinois court has yet considered the question of whether the "benefits" contemplated in §4(d) include penalties and fees an arbitrator may award due to the vexatious and unreasonable behavior of a Respondent-Employer. However, the Commission has previously considered this issue in a few cases. *Walker v. Capitol Transport, Inc., et al.*, 2008 Ill. Wrk. Comp. LEXIS 746; *accord Hampton v. Mark Reynolds, et al.*, 2014 Ill. Wrk. Comp. LEXIS 546. In *Walker*, the Commission interpreted "benefits" to include temporary total disability, medical expenses, and permanent disability benefits. 2008 Ill. Wrk. Comp. LEXIS 746, 14. The Commission stated the "penalties and attorney fees under the Act are clearly extraordinary assessed against a Respondent who acts in an unreasonable and vexatious manner and are not ordinary 'benefits'" contemplated in §4(d) of the Act. *Id.* The Commission determined that the penalties contemplated in §19(k), §19(l), and §16 are designed as punishment for a Respondent's wrongful behavior. The Commission stated the clear intent of §4(d) of the Act is for Petitioners faced with non-complying employers to obtain "the normal benefits of temporary total disability, various medical related, and those regarding permanency or rehabilitation." *Id.* at 15.

The Commission notes that Petitioner did not cite any legal precedent contradicting the Commission's previous interpretation of §4(d) of the Act. Thus, the Commission modifies the Decision of the Arbitrator to reflect the award of penalties and fees are assessed solely against Respondents, Advanced Restoration, LLC and Jason Wiltfang.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 16, 2015, is modified as stated herein.

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

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

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Advanced Restoration, LLC and/or Jason Wiltfang fail to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the

18IWCC0320

benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Advanced Restoration, LLC and/or Jason Wiltfang shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Advanced Restoration, LLC and/or Jason Wiltfang that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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: MAY 24 2018

o: 4/3/18
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SANDOVAL, ARTURO
Employee/Petitioner

Case# **09WC034917**

ADVANCED RESTORATION LLC JASON WILTFANG AND ILLINOIS STATE TREASURER AS CUSTODIAN OF THE INJURED WORKES' BENEFIT FUND
Employer/Respondent

18IWCC0320

On 12/16/2015, 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 0.58% 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.

0391 HEALY SCANLON LAW FIRM
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0000 ADVANCED RESTORATION
4270 GREENTHREAD DR
ZIONSVILLE, IN 46077

0000 JASON WILTFANG
2616 W RICE
CHICAGO, IL 60622

5199 ASSISTANT ATTORNEY GENERAL
MELISSA HINTERHAUSER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Arturo Sandoval
Employee/Petitioner

Case # 09 WC 34917

18IWCC0320

v.

Advanced Restoration, L.L.C., Jason Wiltfang, And the Illinois State Treasurer as Custodian of the Injured Workers' Benefit Fund
Employer/Respondents

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 Workers' Compensation Commission, in the city of Chicago, on **09-14-15**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues circled below, and attaches those findings to this document.

DISPUTED ISSUES

A. Were the Respondents 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 Respondents?

D. What was the date of the accident?

E. Was timely notice of the accident given to the Respondents?

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 amount of compensation is due for Temporary Total Disability?

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

M. Should penalties or fees be imposed upon the Respondents?

N. Are the Respondents due any credit?

18IWCC0320

FINDINGS

- On 5/27/09, the Respondents **Advanced Restoration, L.L.C. and Jason Wiltfang** *were* ~~*was not*~~ operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* ~~*did not*~~ exist between the petitioner and Respondents.
- On this date, the petitioner *did* ~~*did not*~~ sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* ~~*was not*~~ given to the Respondents.
- At the time of injury, the petitioner was 28 years of age, ~~*married*~~ *single* with 2 children under 18.
- Necessary medical services ~~*have*~~ *have not* been provided by the Respondents.
- To date, $500 has been paid by the Respondents on account of this injury.

ORDER

- The Respondents shall pay the petitioner Temporary Total Disability benefits of $268.67 /week for 128 2/7 weeks, from 05/27/09 through 11/11/11, which is the period of Temporary Total Disability for which compensation is payable.
- The Respondents shall pay the further sum of $100,911.46 for necessary medical services, as provided in §8(a) of the Act.
- Respondents shall further pay Petitioner permanent partial disability benefits of $268.67/week for 375 weeks, because the injuries sustained caused the 75% loss of the person as a whole, as provided in Section 8(d)2 of the Act.
- The Respondents shall pay $67,688.99 in penalties, as provided in Section 19(k) of the Act.
- The Respondents shall pay $27,075.59 in fees, as provided in Section 16 of the Act.
- The Respondents shall pay $10,000.00 in penalties, 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 of 0.58 % 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

12-16-15
Date

ICArbDec p. 2

DEC 16 2015

IN THE ILLINOIS WORKERS' COMPENSATION COMMISSION
CHICAGO, ILLINOIS

18IWCC0320

ARTURO SANDOVAL,	)	
	)	
Petitioner,	)	
	)	NO. 09 WC 34917
v.	)	Arbitrator Carlson
	)	
ADVANCED RESTORATION, L.L.C., JASON WILTFANG, and the ILLINOIS STATE TREASURER as CUSTODIAN of the INJURED WORKERS' BENEFIT FUND,	)	
	)	
Respondents.	)	

MEMORANDUM OF DECISION OF ARBIRATOR

Findings of Fact:

In May 2009, Petitioner was employed by the Jason Wiltfang and Advanced Restoration as a painter and power washer. Petitioner's duties included using sanders, grinders, cutting tools, saws and power washers.

On May 27, 2009, Petitioner was working with Jason Wiltfang power washing a building at 1722 W. Harrison Street in Chicago. On that particular day, Petitioner fell from a twenty foot ladder to the ground below. Petitioner was unconscious and was taken by ambulance to Illinois Masonic Hospital.

Petitioner was hospitalized from May 27, 2009 through June 2, 2009. While at Illinois Masonic, Petitioner was diagnosed with thoracic vertebra fractures at T5, T6, and T7 along with a rib fracture and facial fractures of the nose and jaw. On May 28, 2009, Petitioner underwent a

T6 vertebroplasty and placed in a spinal brace. Petitioner testified his nose had to be sewn back onto his face. Petitioner was discharged from the hospital with instructions to stay off work and follow up with the trauma clinic.

Petitioner came under the care of Dr. Havel Deutsch of Rush University Medical Center. Dr. Deutsch performed a series of operations on Petitioner's spine. On February 4, 2010, Petitioner underwent a T4 through T8 fusion with instrumentation. Subsequently, a revision surgery was performed on April 27, 2010. Due to continued pain and urinary incontinence, a second revision surgery was performed on May 25, 2011. (PX5).

On August 26, 2011, Petitioner again was evaluated by Dr. Deutsch. (PX5). At that time, Dr. Deutsch noted continued upper back pain and urinary incontinence. (PX5). Petitioner was prescribed Norco, a Lipoderm patch and Neurontin, and instructed to return to the clinic.

Petitioner returned as instructed on November 7, 2011. (PX5). Petitioner continued to complain of incontinence, back pain and difficulty with balance. (PX5). Petitioner was released to return to work with permanent restrictions of no lifting greater than 35 lbs. (PX5).

Petitioner testified his employer Jason Wiltfang was present with him during his initial hospitalization. Petitioner was paid his regular salary for two weeks after the incident. After those initial two weeks, Respondents failed to pay anything further to Petitioner. Petitioner's employer also failed to pay any medical expenses.

Due to his injury and his employer's refusal to pay workers' compensation benefits, Petitioner developed depression and anxiety necessitating treatment at Advocate Christ Medical Center and Greater Lawn Mental Health Center. (PX2, PX6).

Petitioner testified he continues to experience constant back pain. He has difficulty with both sitting and standing for long periods, along with difficulty carrying things. Petitioner also has difficulty breathing, as the bridge of his nose is collapsed and he had been advised he will need a future surgery to repair it.

Conclusions of Law

(A) Were the Respondents operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

Pursuant to §3 of the Illinois Workers' Compensation Act, Petitioner was employed by Jason Wiltfang and Advanced Restoration and engaged in work activities that trigger the automatic coverage provisions of the Act.

(B) Was there an employee-employer relationship?

Petitioner testified that he was employed by Jason Wiltfang and Advanced Restoration as a painter and a power washer since 2005. The Arbitrator finds and employee-employer relationship existed between Petitioner and Jason Wiltfang and Advanced Restoration.

(C) Did an accident occur that arose out of and in the course of the petitioner's employment by the Respondents?

(D) What was the date of the accident?

Petitioner testified he fell from a twenty foot ladder while power washing a building at 1722 W. Harrison Street in Chicago, on May 27, 2009. Medical records received into evidence confirm that an accident arose out of and in the course of his employment on May 27, 2009.

(E) Was timely notice of the accident given to the Respondents?

Petitioner testified and medical records from Illinois Masonic Hospital confirm that Jason Wiltfang was present at the hospital on the day of the accident and was provided proper, timely notice of the accident.

(F) Whether the petitioner's present condition of ill-being causally related to the injury?

The Arbitrator finds that Petitioner's back injury, facial injury, and mental health issues are causally connected to his work accident on May 27, 2009. Specifically, the Arbitrator finds that Petitioner suffered thoracic vertebra fractures at T5, T6, and T7 along with a rib fracture and facial fractures of the nose and jaw as a result of the work incident on May 27, 2009 that necessitated a T4-T8 fusion with instrumentation by Dr. Deutsch. During his extensive and prolonged care, Petitioner developed depression and anxiety necessitating mental health treatment.

(G) What were the petitioner's earnings?

The record is silent concerning Petitioner's earnings for the fifty-two week period prior to the accident. However, Petitioner testified that he had two children under the age of eighteen. Furthermore, medical records received into evidence indicate that Petitioner was not yet married at the time of the accident. Therefore, Respondents are responsible to pay Temporary Total Disability and Permanent Partial Disability at the minimum rate of $268.67.

(H) What was the petitioner's age at the time of the accident?

Petitioner was twenty-eight years old at the time of the accident.

(I) What was the petitioner's marital status at the time of the accident?

Medical records into evidence indicate that Petitioner was not yet married at the time of the accident.

(J) Were the medical services that were provided to Petitioner reasonable and necessary?

The following certified medical expenses were received pursuant to a valid subpoena and were received into evidence:

Exhibit 9 – Illinois Masonic Medical Center: $54,191.53
Exhibit 10 – Advocate Christ Medical Center: $28,456.28
Exhibit 11 – Mount Sinai Hospital: $4,322.00
Exhibit 12 – University of Illinois Medical Center: $8,750.65
Exhibit 13 – Wellington Radiology: $4,499.00
Exhibit 14 – City of Chicago EMS: $692.00

Given the findings concerning causal connection, the Arbitrator finds Respondents responsible for medical expenses by the above providers pursuant to the fee schedule.

(K) What amount of compensation is due for temporary total disability?

The Arbitrator finds that Respondents are responsible for temporary total disability benefits in the amount of the statutory minimum of $268.67 for the period of May 27, 2009 through November 11, 2011, when Petitioner was released to return to work with permanent restrictions. This totals $34,466.52.

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

Petitioner credibly testified concerning his limitations due to his back injury. After three surgeries, Petitioner still is in constant pain on a daily basis. Petitioner also suffers from incontinence. Petitioner also suffered significant facial fractures that limit his ability to breath.

Petitioner has been placed on permanent restrictions of no lifting greater than 35 lbs. Petitioner also suffers from mental health issues related to his injury and the refusal of his employers to provide workers' compensation benefits.

In light of the above, the Arbitrator finds that Petitioner has sustained 75% loss use of a man as a whole, as provided by §8(d)2 of the Act.

(M) Should penalties or fees be imposed upon the Respondents?

1. Medical Expenses

Respondents failed to pay any medical bills incurred for treatment related to Petitioner's fall. Based on the findings above, and pursuant to McMahan v. Industrial Commission, 183 Ill.2d 499, 702 N.E.2d 545 (1998), the Arbitrator finds Respondents' failure to pay for Petitioner's medical expenses unreasonable and vexatious. As such, Respondents are ordered to pay §19(k) penalties in the amount of $50,455.73. Respondents are further ordered to pay §16 attorneys fees in the amount of $20,182.29, on account of unpaid medical expenses. As noted below, Respondents are also ordered to pay §19(l) penalties at the statutory maximum of $10,000.

2. Temporary Total Disability

The Arbitrator has found that Respondents are responsible for temporary total disability benefits in the amount of $268.67 for the period of May 27, 2009 through November 11, 2011, 128 2/7 weeks, for a total of $34,466.52.

The Arbitrator finds Respondents' failure to pay for Petitioner's temporary total disability benefits unreasonable and vexatious and without good faith basis. As such, the Arbitrator orders Respondents to pay §19(k) penalties in the amount of $17,233.26. The Arbitrator further orders Respondents to pay §19(l) penalties in the maximum amount of $10,000 because the Respondents unreasonably delayed payment of temporary total disability benefits for over six years. Finally, pursuant to §16 of the Act, attorneys fees in the amount of $6,893.30 are ordered paid by Respondents on account of unpaid temporary total disability benefits.

(N) Are the Respondents due any credit?

Petitioner testified that he was paid for two weeks after the accident. Therefore, despite Respondents' failure to present any evidence of entitlement to a credit, the Arbitrator award Respondents a credit of $500.00

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

Monica Harris Williams,

Petitioner,

vs. NO: 16 WC 25175

Bi-State Development Agency/ Metro,

Respondent.

18IWCC0321

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident 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 5, 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.

18IWCC0321

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: MAY 24 2018
o040518
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

HARRIS WILLIAMS, MONICA
Employee/Petitioner

Case# **16WC025175**

BI-STATE DEVELOPMENT AGENCY/METRO
Employer/Respondent

18IWCC0321

On 9/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

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

0088 BROWN & JAMES PC
DAN SANCHEZ
800 MARKET ST SUITE 1100
ST LOUIS, MO 63101-2501

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# ARBITRATION DECISION
19(b)

Monica Harris Williams
Employee/Petitioner

v.

Bi-State Development Agency/Metro
Employer/Respondent

Case # 16 WC 25175

Consolidated cases: N/A

18IWCC0321

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 **August 3, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **February 9, 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$44,570.42**; the average weekly wage was **$857.12**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **1** dependent child.

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

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Melinda M. Pope-Sullivan

Signature of Arbitrator

8/29/17

Date

ICArbDec19(b)

SEP - 5 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Monica Harris Williams
Employee/Petitioner

Case # 16 WC 25175

v.

Consolidated cases: N/A

Bi-State Development Agency/Metro
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on February 9, 2016, she was a bus driver for Respondent and had been for several years. She testified that she worked a split shift, meaning that she worked a morning shift from 5:30 a.m. until 11:30 a.m. or 12:00 p.m., and then began an afternoon shift at 1:30 p.m. which ended at 5:00 p.m. She testified that between her first and second shifts, she had a break of 1.5-2 hours. She testified that she was paid an hourly wage rather than a salary, but was not paid during her break. According to her own testimony, Petitioner did not consider herself on duty.

Petitioner testified that upon arriving to work on the morning of February 9, 2016, she parked her personal vehicle at Respondent's employee-only parking lot at its Illinois bus garage in East St. Louis. She testified that from there, she took a shuttle bus provided by Respondent to the MetroLink station in Washington Park. She testified that she then took a MetroLink train to pick up her bus at the MetroLink station at 5th and Missouri in East St. Louis. She testified that she did not experience any problems driving her bus during her morning shift on the date of the accident.

Petitioner testified that her first shift ended at the Belleville MetroLink station between 11:30 a.m. and 12:00 p.m. She testified that she was to begin her second shift at the 5th and Missouri MetroLink station at 1:30 p.m. She testified that from the Belleville station, she took a MetroLink train to the Washington Park station, and then rode the MetroLink shuttle to the Illinois garage to pick up the vehicle of her co-worker, Pandora Holdman. She testified that her intention was to drive her co-worker's vehicle to the 5th and Missouri MetroLink station, where she would deliver it to Ms. Holdman whose shift would be ending as her afternoon shift began.

Petitioner testified that before heading to the 5th and Missouri MetroLink station, she attempted to stop to eat lunch at Bounce Back Burger on State Street. She testified that as she was turning right into the Bounce Back Burger parking lot, she was rear-ended by another vehicle. On cross examination, Petitioner testified that the accident did not occur on Respondent's premises and that Respondent offered a lunch room on its premises where employees could eat and that she herself had eaten lunch in the lunch room before. Petitioner also confirmed on cross examination that she was not instructed by Respondent to stop and get lunch on her way to the 5th and Missouri MetroLink station on the date of the accident at issue.

On direct examination, Petitioner testified that the hand-drawn diagram on page 2 of the Vehicle Operator Accident-Incident Report accurately represented the positioning of the vehicles during the accident. (RX2). The Arbitrator notes, however, that Petitioner's testimony in this regard is inconsistent

with the other testimony offered and the photographic exhibits introduced into evidence by Petitioner. First, on the Vehicle Operator Accident-Incident Report, an arrow pointing upward indicates the direction of "EAST" and a left-facing arrow was drawn in the circle provided for a north-facing arrow. (RX2). That said, the diagram suggests that the left-to-right path of the vehicles was that of southbound travel. Second, the sections of N. 40th Street which are directly north and directly south of State Street on the Vehicle Operator Accident-Incident Report do not align. Rather, southbound drivers would need to make a right turn on State Street and then an immediate left turn in order to continue driving on N. 40th Street. (RX2). Third, Bounce Back Burger is depicted on the southeastern corner of the intersection, with a parking lot noted to be just east of the building. (RX2). Because of the unique characteristics of the intersection of N. 40th Street and State Street, a vehicle traveling southbound on N. 40th Street would pull straight into the Bounce Back Burger parking lot if it did not "zig zag" to continue on N. 40th Street.

The diagram on the Vehicle Operator Accident-Incident Report depicts both vehicles involved in this accident traveling southbound on what appears to be N. 40th Street, in East St. Louis, traveling directly towards the Bounce Back Burger parking lot. (RX2). Therefore, because Petitioner was rear-ended by the other vehicle, one would expect that other vehicle to have come to rest in the middle of State Street in a south-facing direction. However, the evidence demonstrates that Petitioner and the other vehicle were actually traveling eastbound on State Street at the time of the accident. Petitioner testified on cross-examination that she was rear-ended as she was turning right into the parking lot of Bounce Back Burger. However, Petitioner would only make a right turn into the parking lot if she were traveling eastbound on State Street.[1]

Further, the photographs offered by Petitioner at the time of arbitration show the other vehicle resting in an eastbound direction on State Street, which is shown by the positioning of the Bounce Back Burger building and parking spaces depicted in the photographs and their orientation to the vehicles. (PX12). Ms. Holdman's vehicle is seen at rest with its rear-end in the street and its front-end in the Bounce Back Burger parking lot. (*Id.*). Damage is seen to the right rear of Ms. Holdman's vehicle. (*Id.*)

Petitioner's testimony was that she was turning right into the parking lot, which she would not have done had she been traveling southbound on N. 40th Street, as the parking lot of Bounce Back Burger is directly ahead of where N.40th Street meets State Street. Moreover, on re-direct, Petitioner testified that the vehicle she was driving was in that position as a result of being "shoved" by the other vehicle into the parking lot while her wheels were turned. Petitioner's wheels would not, however, be turned if she was approaching the parking lot from N. 40th Street.

The Arbitrator notes that this clarification is critical because Petitioner testified that she was rear-ended while driving the exact same course she would take had she decided not to stop for lunch at Bounce Back Burger. She testified that she believed the accident would have occurred regardless of whether she stopped for lunch or kept on going to the 5th and Missouri MetroLink station. However, the Illinois garage on 47th Street from which Petitioner was traveling in her co-worker's vehicle is in a generally eastern direction in relation to Bounce Back Burger. Furthermore, 5th and Missouri is in a generally western direction in relation to both Bounce Back Burger and 47th Street. Thus, if one were to take State Street between the garage on 47th Street and 5th and Missouri, one would be driving westbound on State Street, not eastbound as asserted by Petitioner. The Arbitrator infers that the fact that Petitioner was turning right into Bounce Back Burger indicates that she was traveling eastbound on State Street, away from the 5th and Missouri MetroLink station.

Furthermore, Petitioner testified that she slowed down to make a right turn into the Bounce Back Burger parking lot when accident occurred. Therefore, the testimonial and photographic evidence do not

[1] In light of the Arbitrator's admitted unfamiliarity with the streets of East St. Louis, the Arbitrator takes judicial notice of the map of the area at issue as depicted at http://www.cesl.us/admin/upload_file/esl_streets_11x17.pdf.

support Petitioner's claims that she was on the same route she would have otherwise taken had she not stopped for lunch and that the accident would have occurred regardless of whether she stopped for lunch.

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 Gateway Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent x-rays of the cervical spine on February 10, 2016, which were interpreted as revealing (1) degenerative changes with loss of the normal cervical lordosis; (2) no definite evidence of an acute post-traumatic process; (3) if symptoms persist a CT or MRI may prove beneficial. The history was noted to be that of 54-year-old female, motor vehicle accident yesterday, complains of headache and posterior neck pain. Petitioner was seen in the Emergency Department on February 10, 2016, at which time it was noted that she stated that she was rear-ended the day before, that she did not know how fast the driver was going but that her airbags deployed and that her neck was hurting. It was noted that Petitioner complained of neck pain, headache and soreness all over. The ED Nurse Documentation noted that the force of impact was low and that airbags were not deployed. The ED Physician Documentation noted that Petitioner complained of left-sided neck pain following a motor vehicle collision the day before, that Petitioner was the restrained driver of a car struck from behind, that at the time of the accident she did not feel the signs and symptoms although during the course of the evening the left side of her neck tightened up and that she woke up on that date with left-sided neck pain and stiffness. The impression was noted to be that of myofascial cervical strain with paraspinal muscular spasm. (PX3).

The records of Gateway Regional Medical Center reflect that Petitioner underwent physical therapy for the timeframe of March 10, 2016 through March 30, 2016. At the time of the Initial Evaluation/Examination on March 10, 2016, it was noted that Petitioner's chief complaint was that of pain in the left neck radiating into her left shoulder to hand, mostly the thumb, and that she had some complaints of numbness and tingling in the outer part of her arm. It was noted that Petitioner complained of a headache as well. At the time of the March 23, 2016 visit, it was noted that Petitioner stated that her neck was still painful but that her shoulder was 8/10, that it was hurting before the accident and that her left hand was swollen the day before making it difficult to drive. The Discharge Summary dated March 28, 2016 referenced a primary diagnosis of bilateral primary osteoarthritis of the knee as well as an "other" diagnosis of cervicalgia. At the time of the Re-Evaluation/Re-Examination on March 30, 2016, it was noted that Petitioner stated that her neck felt somewhat better and that she was having less pain and more movement with side-to-side movements. It was noted that Petitioner had reported less pain and improved neck range of motion with physical therapy intervention and that her cervical stabilization strength had slightly improved, but that she continued to have range of motion limitations and pain. It was noted that Petitioner also remained tender to palpation and that some sensory deficits were noted in the left upper extremity. (PX3).

The records of Gateway Regional Medical Center reflect that Petitioner underwent x-rays of the left shoulder on April 8, 2016, which were interpreted as revealing (1) no fracture or acute osseous abnormality of the left shoulder; (2) left acromioclavicular and glenohumeral degenerative changes; (3) old left rib fractures. Petitioner also underwent x-rays of the cervical spine on that date, which were interpreted as revealing (1) degenerative disc disease and facet arthropathy; (2) no fracture or acute osseous abnormality of the cervical spine. (PX3).

The medical records of Dr. Peggy Boyd Taylor were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on February 26, 2016, at which time the chief complaint was noted to be that of neck and left shoulder pain radiating into the hand after a motor vehicle accident. At the time of the April 4, 2016 visit, it was noted that Petitioner still had some neck and left shoulder pain. At the time of the June 28, 2016 visit, it was noted that Petitioner reported back

pain/spasms. At the time of the July 28, 2016 visit, Petitioner was seen for "pain management." At the time of the August 25, 2016 visit, Petitioner was seen for back pain. At the time of the November 14, 2016 visit, Petitioner indicated that she was still depressed about her job. It was noted that she complained of low back, neck and shoulder pain at that time. At the time of the December 16, 2016 visit, it was noted that Petitioner was seen for back pain and dietary management. (PX4).

The medical records of Dr. Nathan Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 21, 2016, at which time it was noted that the chief complaint was that of cervical spine and left shoulder pain. It was noted that Petitioner was involved in a motor vehicle accident on February 9, 2016 while working for Metro Transit and was rear-ended in a hit-and-run at State Street in East St. Louis. It was noted that Petitioner went to Gateway Regional Medical Center the next day due to worsening neck pain and shoulder pain, that she currently complained of difficulty extending her neck, pain in the shoulder, on top of the shoulder and deep in the shoulder and that she had gone to her primary care physician where physical therapy had been prescribed but no additional treatment had been performed. Petitioner was recommended to undergo MRIs of the cervical spine and left shoulder. It was noted that Petitioner would also be scheduled for an AC joint injection and biceps tendon injection into the shoulder to help delineate the source of her symptoms. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on August 10, 2016, at which time it was noted that she underwent a left shoulder MRI arthrogram and a cervical spine MRI. It was noted that Petitioner continued to have left shoulder pain and cervical spine discomfort. The assessment was noted to be that of (1) left shoulder biceps tendonitis; (2) left shoulder AC joint arthrosis; (3) left shoulder rotator cuff tear, small. Petitioner was recommended to see a cervical spine specialist. It was noted that Petitioner was also recommended an ultrasound-guided biceps injection as well as an ultrasound-guided AC joint injection. It was noted that Petitioner had a rotator cuff tear which may need to be fixed, but that Dr. Mall wanted to first determine if the AC joint and biceps tendon appeared to be the major sources of her symptoms so that they could be addressed at the same time as the rotator cuff. It was noted that if all of Petitioner's symptoms went away with the injections, then there was the potential that surgery could be avoided as the rotator cuff tear was small and could potentially be rendered asymptomatic with further strengthening and range of motion of the shoulder with physical therapy. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on October 7, 2016, at which time it was noted that she was seen for follow-up of her left AC joint injection and left biceps tendon injection. It was noted that Petitioner was complaining of some right shoulder pain as well. The assessment was noted to be that of (1) left AC joint arthrosis; (2) left biceps tendonitis; (3) left shoulder rotator cuff tear. Petitioner was recommended a Medrol Dosepak, a Mobic prescription and physical therapy for four weeks. It was noted that if Petitioner was still having symptoms at that time, she may require a left shoulder arthroscopy, AC joint resection, rotator cuff repair and biceps tenodesis. At the time of the October 28, 2016 visit, Petitioner was seen for left shoulder complaints as well as pain in the right shoulder. It was noted that the left shoulder was doing better but was not completely perfect yet, but that Petitioner stated that she was doing significantly better following the injections she was given in the AC joint and biceps tendon. The assessment was noted to be that of (1) left AC joint arthrosis, biceps tendonitis and rotator cuff tear; (2) right shoulder AC joint arthrosis and rotator cuff tendonitis. Petitioner was recommended a cortisone injection into the AC joint. It was noted that Petitioner would be seen after continued physical therapy for the left shoulder. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on January 27, 2017, at which time it was noted that she had bilateral shoulder complaints. It was noted that the injections that were provided into the AC joint and biceps tendon seemed to have worn off. The assessment was noted to be that of bilateral shoulder complaints. Petitioner was recommended to undergo a right shoulder MRI arthrogram and it was noted that it would be done as a pre-operative study as it appeared that she would likely require AC joint

resections to both shoulders. It was noted that Petitioner's right shoulder was more symptomatic than the left. (PX5).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent an MRI of the cervical spine on August 10, 2016, which was interpreted as revealing (1) multilevel cervical spondylosis with disc/osteophyte complexes at multiple levels creating impression upon the dura and foraminal narrowing as described; (2) T1-2 bilateral disc protrusions towards the foramina; clinical correlation recommended. Petitioner also underwent an MRI of the left shoulder on the same date, which was interpreted as revealing (1) moderate glenohumeral degenerative changes as described; (2) small 6-7 mm anterior insertional tear of the supraspinatus tendon without retraction with gadolinium extravasation into the subdeltoid bursa; (3) acromioclavicular degenerative changes. The interpretive report for the left shoulder arthrogram also dated August 10, 2016 noted that no full thickness rotator cuff tear was identified. (PX6).

The medical records of Orthopedic Ambulatory Surgery Center of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent Left C5-C6 ILESI with fluoroscopy on November 29, 2016 by Dr. Helen Blake for a pre- and post-operative diagnosis of left cervical radiculopathy. The records further reflect that Petitioner underwent Right C4-C5 ILESI with fluoroscopy on November 15, 2016 for a pre- and post-operative diagnosis of right cervical radiculopathy. The records reflect that Petitioner underwent (1) left shoulder ultrasound-guided biceps injection and (2) left shoulder ultrasound-guided AC joint injection on August 25, 2016 for pre- and post-operative diagnoses of (1) left AC joint arthrosis; (2) left biceps tendinitis. (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 November 2, 2016, at which time it was noted that she presented with a chief complaint of neck pain, central to both shoulders, right greater than left, particularly the right shoulder, right trapezius and also into the left trapezius and left shoulder. It was noted that Petitioner did not recall any previous problems of significance with her neck and had had two previous right shoulder procedures. It was noted that Petitioner's symptoms remained constant and were made worse with fixed head positions, reaching or pulling and were better with a change in position. It was noted that Petitioner had right shoulder pain and left shoulder pain, but that the right seemed to be worse. Petitioner was recommended to undergo steroid injections and it was noted that they would attempt treat the majority of her neck and trapezial pain with an injection on the right at C4-5 and on the left at C5-6. Petitioner was referred to Dr. Blake for injections. (PX8).

The records of Dr. Gornet reflect that Petitioner was seen on January 5, 2017, at which time it was noted that pre-operative studies revealed preexisting degeneration with fairly severe stenosis and that her disc pathology was predominantly at C4-5, C5-6 and C6-7. It was noted that Petitioner was still having significant headaches in addition to her neck pain and bilateral trapezial pain and that the right-sided symptoms were worse than the left. It was noted that Petitioner may require cervical disc replacement at at least 4-5, 5-6 and 6-7. Petitioner was recommended to undergo a CT myelogram. It was noted that consideration may be given to treating C3-4 also, but that this would largely be determined based on further objective studies. It was noted that the injections she had by Dr. Blake on November 15th and November 29th gave Petitioner only about a month of relief and that her symptoms had returned. At the time of the February 23, 2017 visit, it was noted that Petitioner's CT myelogram was reviewed and that Dr. Gornet believed that she had some level of facet arthropathy at the 3-4 level bilaterally and that there may be a little bit on the right side at 4-5 and 5-6 appeared to be fairly normal. It was noted that Petitioner's facet arthropathy was not severe enough to make her not a candidate for cervical disc replacement. It was noted that Petitioner may require supplemental procedures including a foraminotomy on the left at C3-4 posteriorly as well as C5-6 and even C6-7. It was noted that Petitioner's main complaint was neck pain to both shoulders, right greater than left, particularly the right shoulder and right trapezius. Petitioner was again recommended to undergo three level disc replacement at C4-5, C5-6 and C6-7. (PX8).

The records of Dr. Gornet reflect that Petitioner was seen on May 13, 2017, at which time it was noted that she brought with her the IME report of Dr. Mirkin. It was noted that Dr. Gornet believed that Petitioner was not a candidate for surgery as long as she continued to take narcotics. It was noted that Petitioner was due to have surgery by Dr. Mall on the left shoulder on May 18, 2017 and that she understood that a portion of her shoulder pain may be coming from her cervical spine. It was noted that they had again discussed narcotics and other than that prescribed by Dr. Mall, she was to be off all other narcotics. At the time of the July 24, 2017 visit, it was noted that Petitioner had had surgery by Dr. Mall and seemed to be doing well. It was noted that Petitioner continued to have neck pain central, right greater than left, particularly to the right shoulder and right trapezius with similar symptoms on the left. It was noted that Petitioner understood a portion of her shoulder symptoms were related to her neck and that it was one reason why she still had pain even though she had had a successful surgery. It was noted that approval was sought for surgery. (PX8).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent a cervical spine CT myelogram on February 23, 2017, which was interpreted as revealing (1) lobulated bilateral foraminal protrusions at C5-6 with central broad-based protrusions at C3-4, C4-5, C6-7 and C7-T1; bilateral foraminal stenoses are present at all of these levels; there is no central canal stenosis. (PX9).

The IME Report of Dr. Mirkin dated April 19, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report noted that Petitioner claimed that she was injured on February 9, 2016 when she was driving a co-worker's car and was rear-ended by another car. It was noted that Petitioner indicated that she developed severe pain in her neck and her left shoulder, that she did not go to the hospital until the next day and that she claimed she had had symptoms that occurred immediately. It was noted that Petitioner treated with therapy, medications and injections and that she was told she needed surgery in her left shoulder. It was noted that Petitioner was referred to another doctor for her neck. It was noted that Petitioner indicated that she had pain in her neck, occasional radiating pain down the left arm, down to the left shoulder blade and no numbness or tingling in her hands. It was noted that it was Dr. Mirkin's impression that Petitioner had severe end stage arthritis of the cervical spine, arthritic changes in the left glenohumeral joint and AC joint and a small rotator cuff tear. It was noted that regarding the left shoulder, if Petitioner could not live with it the appropriate treatment would be an arthroscopy and repair and possible subacromial decompression. It was noted that regarding the neck, Petitioner had significant end stage arthritic disease, that the pathology preexisted the incident in question and that there was no indication on the MRI or the myelogram of an acute injury. It was noted that Petitioner's options were to live with the condition and continue the exercises, and that if she could not live with it, a laminectomy or discectomy and fusion procedure would be indicated. It was noted that Petitioner had significant contraindications to disc replacement surgery (particularly more than two levels), that disc replacements were contraindicated in patients who had significant arthritic facet disease and that Petitioner had very severe facet disease. It was also noted that it was contraindicated in more than two levels. (PX10).

The transcript of the deposition of Dr. Matthew Gornet was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Dr. Gornet testified that he is a board-certified orthopedic surgeon whose practice is devoted to spine surgery. (PX11).

Dr. Gornet testified that he first saw Petitioner on November 2, 2016 at the referral of Dr. Mall. He testified that he did not have any opinions regarding either the right or left shoulders as this was not his area of expertise. He testified that he had plain x-rays performed at the office, which revealed some loss of disc height at C4-5, C5-6 and C6-7 and that he felt that there was some foraminal stenosis on oblique views on the left at C6-7 and on the right at C6-7. He testified that he reviewed an MRI from August 10, 2016, which also revealed some multilevel disc degeneration, spondylosis and fairly severe foraminal stenosis on the left at C5-6 and on the right at C4-5. He testified that he felt that there were acute and chronic herniations with some pathology present at 3-4, 4-5, 5-6 and 6-7. He testified that he felt that Petitioner's symptoms

were related to disc injury and to some extent whiplash injury, injury to the disc and disc mechanism, particularly at C4-5, C5-6 and C6-7, as well as aggravation of what he felt was some preexisting foraminal stenosis and disc degeneration. He testified that he felt that Petitioner's symptoms were related to her accident of February 9, 2016. He testified that he recommended injections in the cervical spine and motion analysis studies, which indicated a 99.99999% chance that Petitioner had a disc injury objectively at C4-5, C5-6 and C6-7. (PX11).

Dr. Gornet testified that Petitioner returned after the injections and that she did not obtain significant relief. He testified that he discussed with Petitioner that he felt that she would require disc replacement at C4-5, C5-6 and C6-7 and that he wanted to do a CT myelogram in large part to determine whether he needed to treat C3-4 as part of her symptoms. He testified that the CT myelogram was performed and was of diagnostic quality. He testified that at the levels he wanted to treat Petitioner for her injury (*i.e.*, C4-5, C5-6 and C6-7), she did not have significant facet arthritis. He testified that the first area that Petitioner had some mild facet arthritis bilaterally was at C3-4, but that the current plan was not to treat that. (PX11).

Dr. Gornet testified that Petitioner has substantial problems with her cervical spine, has issues with her quality of life and that her work value is reflective of her motivation. He testified that he believed that if Petitioner did not have the surgery, her ability to work would be compromised in the near future. He testified that he was contemplating a full duty return to work and that he has performed this surgery in multiple patients and that clinical success has generally been outstanding. He testified that if Petitioner had a three-level fusion as the alternative, she would have profound restrictions and that he did not believe that she would ever return to work in commercial driving. (PX11).

On cross examination, Dr. Gornet testified that he did not have any information regarding the speed at which Petitioner was traveling or the speed that the other vehicle was traveling. He agreed that Petitioner continued to drive buses in the months following the incident. (PX11).

On cross examination when asked why Petitioner's complaints shifted from the left to the right, Dr. Gornet responded that he had both shoulders noted but that at the first visit, he noted right greater than left. He testified that he did not have a great explanation. He testified that Petitioner did not recall any problems of significance or treatment with regard to her spine, but that she did indicate that she had right shoulder procedures in the past. (PX11).

On cross examination, Dr. Gornet testified that he thought that the motor vehicle accident aggravated the preexisting foraminal stenosis, that there was a strong suggestion of a disc fragment at C5-6, C6-7 on the right side that appeared more acute in appearance and that she had preexisting disc osteophytes at several other levels that would easily be aggravated. (PX11).

On redirect, Dr. Gornet testified that the plan of discectomy and fusion at C4 to C7 would increase substantially the mechanical loads on the cervical spine at C3-4 and make the patient more symptomatic there as well as C2-3. He testified that Dr. Mirkin's plan had a reoperation rate of approximately 40% and that the restriction of motion C4 to C7, in addition to causing adjacent level stress at the other levels, would significantly limit Petitioner's ability to work as a commercial driver (PX11).

The Vehicle Photographs were entered into evidence at the time of arbitration as Petitioner's Exhibit 12.

The transcript of the deposition of Dr. Peter Mirkin was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Mirkin testified that he is an orthopedic surgeon. (RX1).

Dr. Mirkin testified that he performed on IME on Petitioner and that she reported that she had been injured on February 9, 2016. He testified that Petitioner reported that she was driving a co-worker's car

and was rear-ended by another car. He testified that Petitioner reported to him that she developed neck pain and pain in her left shoulder, that she went to the hospital the next day and that indicated that she had pain in her neck with occasional radiating pain down the left arm, down the left shoulder blade and that she had no numbness or tingling in her hands. He testified that Petitioner reported that her spine doctor recommended injections and a three-level disc replacement in her neck. (RX1).

Dr. Mirkin testified that in addition to various medical records and diagnostic films, he reviewed x-rays of Petitioner's neck taken in the office and that she had very severe arthritis with collapsing disc space and facet arthritis at essentially every level. He testified that he believed that Petitioner had very severe arthritis of the cervical spine and that she indicated that she developed pain after the incident in question. He testified that the height of the disc was a fraction of what it should be, that it narrowed down as they saw in degenerative disease, that her neck was bent forward (*i.e.*, loss of lordosis) and that she had calcified spurs at almost all of the levels from C3 down to T1. (RX1).

Dr. Mirkin testified that he opined that the motor vehicle accident may have aggravated her preexisting condition and that she may need a laminectomy or a discectomy and fusion. He testified that Petitioner had severe disease from C3 to T1, and that most physicians would incorporate 5-6, 6-7 and maybe 4-5. When asked if he had an opinion as to what level specifically may be causing her complaints, Dr. Mirkin responded that Petitioner's biggest complaint was axial neck pain and that she also had some radiating pain down her shoulders. He testified that the axial neck pain was probably caused to some degree by all of the levels and that the radiating pain would be in the C5-6 or C6-7 distribution, but that it was very difficult to pin down specifically given no electrodiagnostic studies or any nerve dysfunction on examination. (RX1).

Dr. Mirkin testified that disc replacements were contraindicated for Petitioner because she had severe arthritis with collapse of the disc space and that they were not approved for more than two levels. He testified that Dr. Gornet was recommending three levels, which was an absolute contraindication based on the medical literature, the manufacturer's recommendation and the FDA recommendation. He testified that he did not agree with Dr. Gornet's assertion that there was no significant facet arthropathy at C4-5, 5-6 and 6-7 and that in looking at the x-rays, one could see the facet arthritis and that there was collapse of the facets at all of the levels in addition to bone spurs. (RX1).

On cross examination, Dr. Mirkin testified that he occasionally performs disc replacement surgery in his practice, that he performs a couple per year and that he has removed more than he has performed. He testified that he goes by the absolute indications (*i.e.*, a herniated disc with a well-hydrated disc without significant degenerative disease) and that most of the patients he treats have some degree of degenerative disease, that he does not think that they do as well as other options and that most of the insurance companies would not approve them. (RX1).

On cross examination, Dr. Mirkin testified that he believed that the best option was for Petitioner to live with her condition but that if she could not do so, he did not think that she met the criteria in any of the accepted indications for three-level disc cervical disc replacement. He testified that he was not provided with the result of the motion analysis that Dr. Gornet performed and that it was not an accepted study. (RX1).

On cross examination, Dr. Mirkin agreed that when treating a patient and deciding what treatment recommendations to make, he takes into account not only what he may see on a CT or MRI but that he also takes into account their symptoms. He agreed that if someone had significant degenerative findings on a CT or MRI but they were not having symptoms, he most likely would not recommend any treatment for them or any surgery. He testified that the indications for surgery were symptoms, that the patient failed conservative care and that there was an anatomical condition that could be corrected surgically. (RX1).

On cross examination, Dr. Mirkin testified that he was not aware of how many disc replacement surgeries Dr. Gornet did nor did he know what his involvement was in clinical trials and research following patients who had cervical disc replacements. When asked if he had any information about what Dr. Gornet's outcomes had been following multi-level disc replacement surgery, Dr. Mirkin responded that he had seen in his office were "dismal." He testified that he sees one or two patients per year having revision surgery on disc replacements. (RX1).

On cross examination, Dr. Mirkin testified that he believed that some physical therapy, injections and an MRI or myelogram would be reasonable and necessary for the accident of February 9, 2016, but that the motion analysis was not necessary and was not an accepted study in most practices or by the academies for this type of treatment. He agreed that he did not indicate in his report that Petitioner was exaggerating her symptoms or malingering. He testified that he had no idea what Petitioner's current pain level is. (RX1).

The Vehicle Operator Accident-Incident Report was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report noted that while on break in between relieving another driver and driving her co-worker's car to the relief point, Petitioner was going east on State to Bounce Back Burgers, making a right turn into the parking area. It was noted that a car came from out of nowhere and hit the vehicle in the rear right while she was making the turn. It was noted that the other vehicles' air bags popped out. It was noted that the other vehicle sped off. (RX2).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner failed to prove that she sustained an accidental injury on February 9, 2016 that arose out of and in the course of her employment with Respondent.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.*

In the case at hand, the evidence reflects that Petitioner was not performing any acts at the instruction of Respondent, nor did she have a common law or statutory duty to perform the act of going to lunch. Furthermore, Petitioner's act of deviating from her course of employment to go to lunch was not reasonably expected as incidental to her assigned duties, because going out to lunch was not incidental to her job duties. Even if it was, Petitioner testified that she had the option of eating in Respondent's lunch

room, which she admitted she had done in the past. Therefore, the origin of the injury did not arise out of her employment.

"In the course of the employment" refers to the time, place, and circumstances under which the claimant is injured. *Johnson,* 2011 IL App (2d) 100418WC. 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 or after work, are generally deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill.2d at 57.

The *Johnson* case involved a police officer who was injured in a motor vehicle accident when he was responding to a call following a deviation from his employment to run personal errands. The employer argued that the employee's injuries were not sustained in the course of his employment because, except for his deviation, he would not have been driving through the intersection where he was injured.

> "Generally speaking, a deviation for purely personal reasons takes an employee out of the course of his employment. And in this case, there is no question that, prior to having received the radio assignment to assist deputy Kirsch, the claimant was engaged in a purely personal deviation which took him into Du Page County. The question remains, however, whether, at the time of his injury, the claimant had completed his deviation and resumed a course of conduct related to the business to his employer such that he could be said to have been in the course of his employment." *Johnson,* 2011 IL App (2d) 100418WC.

In this case, Petitioner was injured in an accident on her way to lunch, off of Respondent's premises. This lunch break was a purely personal deviation from the course of her employment and Respondent did not exercise any control over her at the time of her injury, before she was to resume a course of conduct related to the business of her employer. Thus, the *Johnson* decision supports Respondent's defense that Petitioner's injury did not arise in the course of her employment. Furthermore, unlike *Johnson*, there can be no question that the employee had not completed her deviation from course, and she admitted in her testimony that she was on her way to get lunch and was not traveling to her next shift from Bounce Back Burger.

In sum, the Arbitrator finds that Petitioner's injuries did not arise out of and in the course of her employment because she was on a personal break at the time of the accident and deviated from her course to get lunch at Bounce Back Burger. The evidence reflects that at the time of the accident, Petitioner was traveling away from the 5th and Missouri MetroLink station at which she was scheduled to start her next shift and had slowed down to make a right turn into the parking lot. Thus, Petitioner cannot be said to have been taking the same route she otherwise would have taken to get from the Illinois garage to the 5th and Missouri MetroLink station and that the accident would have occurred regardless of Petitioner's deviation. In fact, the evidence shows that Petitioner was travelling in the opposite direction from where her next shift was to start at the time of the accident. Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that she sustained an accidental injury on February 9, 2016 that arose out of and in the course of her employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (F) pertaining to causation, (J) pertaining to reasonable and necessary medical expenses and (K) pertaining to prospective medical treatment, as those issues are rendered moot. The claim is denied.

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

Jerri Tincher,

Petitioner,

vs. NO: 16 WC 31297

Kroger,

Respondent.

18IWCC0322

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 total disability, medical expenses, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 20, 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.

MAY 24 2018

DATED:
o050318
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

TINCHER, JERRI
Employee/Petitioner

Case# **16WC031297**

KROGER
Employer/Respondent

18IWCC0322

On 11/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.36% 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:

0157 ASHER & SMITH
CRAIG SMITH
1119 W MAIN ST
PARIS, IL 61944

5196 CLAYBORNE SABO & WAGNER
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62222

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
19(b)

JERRI TINCHER
Employee/Petitioner

v.

KROGER
Employer/Respondent

Case # **16** WC **31297**

Consolidated cases: **N/A**

18IWCC0322

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **September 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

18IWCC0322

On the date of accident, **August 23, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$33,904.00**; the average weekly wage was **$652.00**.

On the date of accident, Petitioner was **45** 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 **$4,297.56** for medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that her current condition of ill-being in her right knee is causally related to her accident of August 23, 2016. 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

November 14, 2017
Date

ICArbDec19(b)

NOV 20 2017

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

On July 29, 2013 Petitioner was seen at the Family Medical Center in Paris, Illinois, regarding right knee pain which had been ongoing for quite some time. According to Dr. Guinto's notes, Petitioner reported the pain was worse lately and she was feeling a grinding sensation every time she moved around. Petitioner further reported engaging in a lot of squatting and lifting at work. Her knee was quite stiff and painful in the morning but would worsen during the later part of the day. She could identify no specific injury. X-rays taken of her right knee showed a focal sclerotic lesion of the medial distal femur with periosteal reaction. Petitioner was referred to orthopedics (Dr. Rowe) to rule out a malignant process in her right knee. (RX 1, p. 2; RX 2, p. 52)

Petitioner was next examined by Dr. Rowe on April 31, 2014. Her job as a meat cutter at a supermarket was noted. Her hobbies included hunting mushrooms and fishing. Petitioner was being seen at Dr. Guinto's request for insidiously progressive bilateral knee pain, presently worse on the left than the right. Petitioner reported difficulty getting in and out of a chair, going up and down stairs, and sitting in one position for an extended period of time. She reported catching, popping and locking in her left knee with both posterior and anterior knee pain. She had been taking Mobic but then changed to Voltaren. Petitioner was also taking 18 to 20 Ibuprofen on a daily basis. Dr. Rowe noted an antalgic gait, left greater than the right, with a marked inability to squat. She had severe patella femoral grind and crepitus with somewhat medially displaced patellas due to torsion of the femurs. Petitioner exhibited positive McMurray, Balance and Spring signs on the left. X-rays of Petitioner's right knee suggested a dense lesion in the distal medial femur. Patella femoral arthritis was also evident on the right side. Dr. Rowe felt Petitioner had moderately severe bilateral patella femoral arthritis due to malalignment and hypertrophic trochlea and external torsion of the femurs. She also had a benign appearing lesion on the distal medial femur and mechanical symptoms on the left side suggesting a medial meniscus tear. Dr. Rowe recommended a left knee MRI and he was going to speak to the radiologist regarding the need for a right knee MRI. (RX 3, p. 74)

Petitioner continued to see Dr. Rowe after April 31st regarding her left knee and she ultimately underwent a left knee total replacement. (RX 3, pp. 144 – 150)

Petitioner returned to see Dr. Rowe on June 26, 2015 nineteen weeks post total left knee replacement. Her right knee patella femoral arthritis was mentioned and she underwent an injection to that knee. She was to return in one year unless she needed to return sooner. (RX 3, p. 75)

Petitioner returned to see Dr. Rowe on November 17, 2015 regarding increasing retropatellar pain with significant grind, compression and effusion in her right knee. Due to the moderately good results from past injections, they proceeded with another one. They also discussed the options of moving forward with a patellofemoral arthroplasty or a total knee arthroplasty. (RX 3, p. 76)

Dr. Rowe re-examined Petitioner on March 22, 2016. Petitioner's left knee was doing well but her right knee was getting progressively worse with increased pain, swelling and difficulty with stairs, squatting, and kneeling. She was continuing to take anti-inflammatory medication. Petitioner displayed difficulty toe walking and squatting with the right knee. She had positive effusion and severe patellofemoral grind and crepitus with hypomobility and significant guarding atrophy of the quadriceps

muscle. Petitioner underwent another injection to her right knee. They discussed smoking cessation and options. She was to return as necessary. (RX 3, pp. 77 – 79)

Petitioner worked 40 hours for Respondent between August 21, 2016 and August 27, 2016. (RX 7)

Petitioner worked 40.25 hours for Respondent between August 28, 2016 and September 3, 2016. (RX 7)

Petitioner worked 40 hours for Respondent between September 4, 2016 and September 10, 2016. (RX 7)

On September 6, 2016 at approximately 3:00 p.m. Petitioner notified Danielle Montgomery of a fall. (RX 6)

Petitioner took 40 hours of vacation time between September 11, 2016 and September 17, 2016. (RX 7)

While on vacation time, Petitioner returned on September 14, 2016, to see Dr. Rowe (PX 1). Petitioner reported that on either August 28 or 29th, she fell while stepping into a freezer, tripping on worn down safety pads. She reported falling onto the anterior aspect of her right knee, causing her to experience immediate pain and significant swelling, but no pop, crack, or tearing sensation. Dr. Rowe recounted that Petitioner had a history of prior pain in her right knee due to her patellofemoral arthritis diagnosis, which had been treated in the past with intermittent corticosteroid injections. He had been able to adequately hydrate it in the past with intermittent corticosteroid injections. Petitioner was reporting that on this occasion the pain was persistent with significant swelling. She was unable to kneel, squat or go up and down stairs comfortably. She had attempted to moderate her symptoms with ice and diclofenac and was "slightly better" than immediately after the fall. On examination Petitioner had a significant antalgic gait on the right with increased pain when attempting to walk on her toes. A markedly impaired ability to squat on the right side was noted. Effusion was measured at "2+." She also had slight medial joint line tenderness and a negative spring sign. There was no evidence of instability. Dr. Rowe diagnosed her with an exacerbation of the pre-existing patellofemoral arthritis of right knee and performed a corticosteroid injection. She was continued on the Norco 10 mg, which she had been on since December of 2014 (RX 2, Resp. 0024-0050; RX 4, 0089-0094). The doctor wrote:

> The causation indicis examiner's opinion that the patient's need for medical care arose out of and during the course of her usual and customary work as a consequence of a fall onto the anterior aspect of her right knee. It is my opinion that she sustained a work-related exacerbation of [her] pre-existing patellofemoral arthritis. It is my understanding that she is eligible for care that would return her to a pre-injury level without permission for permanent residual disability based upon the anticipated disability related to her pre-existing patellofemoral arthritis." (PX 1)

The doctor felt Petitioner was temporarily totally disabled and not yet at maximum medical improvement. (PX 1)

On September 15, 2016 Petitioner completed an Employee Incident Injury/Illness Report. She gave an accident date of August 23, 2016 and a time of injury as 11:30 a.m. Petitioner explained that she was pulling a skid of frozen out of the freezer and slid on the floor, landing on her right knee. She mentioned that the safety strips on the floor were worn. At the time of the incident she was using a hand jack to move the skid. Petitioner stated she advised Danielle Montgomery, Respondent's manager, on September 6, 2016. (RX 6)

An Associate Incident Report Packet was sent to Sedgwick CMS on September 15, 2016. In the cover note, mention was made of an incorrect incident date. Rather than "September 6, 2016," the incident date was suggested to be August 23, 2016. (RX 6) Included in the Packet was a "Questionable Claim Form." According to it, the claim was being questioned because when Petitioner originally reported it on September 6, 2016 she indicated a report was not needed as she was not hurt; rather, she just wanted the strips replaced so no one would get hurt. However, she then returned nine days later, after being on vacation, and had "recent looking bruises on her knee, has had knee replacement surgery and has had trouble with knees since surgery." (RX 6)

Petitioner worked 18 hours for Respondent between September 18, 2016 and September 24, 2016. (RX 7)

On September 23, 2016 Petitioner was given a Constructive Advice Record and indefinitely suspended as of September 23rd because she was observed on September 22, 2016 eating in the breakroom while on the clock and purchasing food while on the clock, contrary to company policy. (RX 8)

Petitioner returned to see Dr. Rowe on September 30, 2016 secondary to her fall at work on August 23, 2016. Petitioner complained of persistent pain and swelling making it difficult for her to climb stairs and squat or kneel or be in a "standard" position for an extended period. Pain was appreciated along the medial joint line and anteriorly. Petitioner also reported episodes of catching, buckling and giving away. Dr. Rowe noted that at the initial evaluation every effort had been made to return her to work with a prescription for medications, that Petitioner required food to moderate her upset stomach caused by the medications, and that while eating at work she was terminated. Upon physical examination, Petitioner had an antalgic gait on the right side with positive effusion, tenderness along the medial joint line of the right knee, and pain with full terminal extension. Petitioner had a positive bounce negative spring sign and significant patellofemoral grind and crepitus. Petitioner was diagnosed with internal derangement of the right knee. Dr. Rowe recommended that x-rays and an MRI be performed. The x-rays demonstrated some chondral sclerosis in the tibia both medially and laterally with some early marginal spur formation. She also had subchondral cystic changes in the medial tibial plateau. Some joint space remained. There was evidence of patellofemoral arthritic changes. His assessment was a fall exacerbating pre-existing right knee patellofemoral arthritis. He was also concerned about a medial meniscus tear. She remained temporarily totally disabled with restrictions of no kneeling, squatting, stair climbing or ladders. Petitioner was told to primarily sit but stand and walk as needed. (PX 1)

On September 30, 2016, Petitioner presented to Paris Community Hospital for x-rays of her bilateral knees. (PX 1) The x-ray of the right knee was compared to a previous x-ray performed on March 22, 2016. The x-ray revealed osteoarthritic changes of the right knee, as well as the sclerotic bone lesion in the distal right femur. It was recommended that Petitioner undergo a nuclear bone scan to determine if the bone lesion was an active abnormality or not.

On October 1, 2016 Petitioner was given a Constructive Advice Record which she refused to sign. She was placed on 30 days probation for being observed outside the store smoking while on the clock, contrary to company policy. (RX 8)

Petitioner signed her Application for Adjustment of Claim herein on October 4, 2016 alleging an accident date of August 23, 2016. (AX 2)

On October 19, 2016 Petitioner was terminated. (RX 8)

On October 22, 2016, Petitioner presented to the Paris Community Hospital emergency room with complaints of right knee pain and a contusion that were "acute," along with swelling and tenderness. (PX 2) Petitioner gave a history of injuring herself at work on September 9th when she fell on her right knee and for which she was seeing Dr. Rowe. She was waiting for approval to undergo an MRI but, in the interim, the Norco wasn't easing her pain. She described bulging veins in the back of her right leg and bruising along with a swollen and painful knee cap. (PX 2)

The arrival notes reflect that the problem was "sustained at home, resulted from an unknown cause". (RX 2, p. 0151). The notes also state that the symptoms/episode began/occurred acutely that morning and that Petitioner had experienced similar episodes in the past, multiple times. It was noted that there was "new bruising to right knee and pain" this morning. Petitioner also reported an initial injury to her right knee on September 9, 2016 when she fell at work landing on her right knee; however, she did not get it checked out until 3 weeks later and had been diagnosed with advanced arthritis. Petitioner further reported being fired from work recently. Authorization for an MRI was pending with workers' compensation. Petitioner was worried about a blood clot and, therefore, presented to the emergency room. On exam, Petitioner's knee was swollen and tender. A contusion was noted and Petitioner complained of pain. A new x-ray was performed and compared to the x-rays from July 29, 2013 and September 30, 2016, but failed to reveal any new injury. Petitioner was advised to follow up with her primary care doctor within a few days. (RX 2, p. 0155).

Petitioner underwent no medical treatment for her right knee between October 22, 2016 and December 5, 2016.

On December 6, 2016, Petitioner returned to Dr. Rowe following the MRI of her right knee[1]. Her complaints included pain, episodes of catching and buckling, as well as severe patellofemoral crepitus and grinding. (PX 1) She had an antalgic gait on the right side and positive McMurray's for the medial compartment. Effusion, medial joint line tenderness and medial parapatellar tenderness was also noted. There was no evidence of instability. The MRI was read as showing some small effusion and a tear of the posterior horn of the medial meniscus. She also had advanced arthritic changes of the patellofemoral joint and a benign-appearing proximal tibial lesion which was described as long-standing. The assessment was that of a tear of the medial meniscus of knee and patellofemoral osteoarthritis. Dr. Rowe noted, "It did seem that the falls served to exacerbate her pre-existing arthritis and "may have resulted in a medial meniscus tear." He kept her restrictions in place Dr. Rowe recommended arthroscopy of the right knee with meniscectomy versus repair, as well as chondroplasty of the patella and possible lateral retinacular release. (PX 1)

On December 19, 2016, Petitioner presented to Paris Community Hospital for surgical intervention with Dr. John Rowe. (PX 3) His pre-operative diagnosis was a right knee medial meniscus

[1] Not a part of the record.

tear. The post-operative diagnoses included: right knee medial meniscus tear; Grade 4 chondromalacia of the patella, especially the lateral facet and trochlea; Grade 3 chondromalacia of medial tibial plateau; and Grade 3 chondromalacia of lateral tibia plateau. Surgery included an arthroscopy of Petitioner's right knee with a partial meniscectomy, an abrasion arthroplasty of the trochlea and patella, and a chondroplasty of the medial and lateral plateaus. Intra-operative findings included extensive articular cartilage loss throughout the patella, in the trochlea extending all the way down to the inner condylar notch with marginal flap formation. Dr. Rowe also noted a tear of the anterior horn of the medial meniscus that was actually rolled up underneath on itself. The posterior horn of the medial meniscus appeared normal. A partial medial meniscectomy of the anterior horn was performed. (PX 3)

Petitioner followed-up with Dr. Rowe post-surgery on December 20, 2016. She was reportedly doing well and had slept for about 4 hours the night before. She rated her pain at a "7/10" and was using cryotherapy for her symptoms. She was to return on January 3, 2017. (PX 1)

Petitioner presented to Paris Community Hospital for an Initial Therapy Evaluation on December 20, 2016. Petitioner's chief complaint was pain (8/10) located behind her kneecap and along the medial joint line. It was aggravated by walking, standing and prolonged positions. Petitioner reported pulling a skid out of the freezer on September 6, 2016 when she fell straight onto her kneecap due to a slick floor. Her pain continued to worsen thereafter and her knee would buckle and give out on her. Petitioner appeared to be doing very well that day and had a good quad set. It was recommended that she undergo therapy three times a week for about one month. (PX 4)

Petitioner attended physical therapy on December 22, 2016 reporting pain behind her kneecap along with medial joint line pain. She also complained of some numbness around her kneecap. She was walking very short distances and not standing for more than five minutes. She was using a rollater. The therapist also noted "grinding in Petitioner's knee with open chain knee extension and minimal grinding with CKC TKE." (PX 4)

Petitioner also attended physical therapy on December 28, 2016 with ongoing complaints of pain and numbness and lots of grinding any time she would bend her knee or put weight on it when walking or standing. Tolerance was described as moderate with grinding and popping in the knee upon flexion and gait. (PX 4)

Petitioner returned for physical therapy on December 30, 2016 reporting ongoing complaints as before but with more pain behind and underneath her kneecap. She also reported more grinding on it than before her surgery. The therapist noted moderate complaints of pain and difficulty with therapy. Petitioner also had a moderate amount of grinding with any activities involving knee flexion. Only straight leg activities were performed. The therapist expressed concern about the grinding in Petitioner's knee. (PX 4)

At her next therapy appointment on January 3, 2017 Petitioner reported significant pain and swelling and grinding "worse than it was prior to surgery." It was noted that Petitioner had excellent range of motion and strength but moderate grinding with simply flexing and extending her knee. Petitioner was scheduled to see an orthopedic nurse practitioner that day as her orthopedic physician no longer worked at Paris. The therapist recommended Petitioner get a referral to an orthopedist as her grinding had increased since the surgery. (PX 4)

Petitioner returned to see Dr. Rowe on January 3, 2017 but was examined by his nurse practitioner, Angie Hamilton, as Dr. Rowe was no longer at Paris Hospital. Her stitches had been

removed on December 30, 2016. Petitioner reported her knee had been swelling and she had been hearing and feeling some grinding when moving her knee which had started soon after surgery. Petitioner was also complaining of right knee pain. Upon examination Petitioner reported some tenderness but there was no swelling and appropriate range of motion. She was to return in four weeks and use ice and elevate her knee. (PX 1)

Petitioner cancelled her therapy appointment on January 5, 2017 reporting that Angie Hamilton had told her she didn't need any more therapy. (PX 4)

On January 12, 2017 Petitioner presented to Dr. Rahat Sheikh reporting right knee pain. The doctor noted she had undergone surgery three weeks earlier and she was in the process of getting a new orthopedic specialist but needed pain medications refilled in the interim. Petitioner was taking Norco and Voltaren. Both medications were refilled. On examination Petitioner had tenderness medially and laterally in her right knee. (PX 5)

On January 31, 2017, Petitioner presented to Dr. Sandercock, an orthopedic surgeon, per the request of Dr. Sheikh. Petitioner reported undergoing surgery on December 19, 2016 but that her surgeon was no longer employed at Paris Hospital. She denied any follow-up appointment since her surgery. She reported continued 7/10 pain and grinding in her knee, noting she fell in a freezer onto her right knee on September 6, 2016. Petitioner no longer worked for Respondent. Petitioner's medications included Norco, Diclofenac, Xanax and Zoloft. Her knee had 0 to 130 degrees of range of motion with tremendous patellofemoral crepitus. She also had tremendous quad atrophy with 4/5 strength in her flexors and extensors. Medial joint line tenderness was present and a positive ballottement test was found. Apprehension and instability were negative. Dr. Sandercock recommended aggressive physical therapy and asked Petitioner to try and get copies of her arthroscopy. She wished for pain medication and was told to continue getting that from Dr. Sheikh. Petitioner expressed the feeling that her surgery did not do much to resolve her problem. Dr. Sandercock wrote that she had a "traumatic exacerbation" of an underlying arthritic problem and might require a knee replacement in the future. (PX 6)

Petitioner again presented to Dr. Sheikh on February 1, 2017 regarding her ongoing knee pain. She had seen Dr. Sandercock who wanted Dr. Sheikh to prescribe her Norco. She also reported that Dr. Sandercock was sending her to physical therapy. The doctor refilled the prescription. (PX 5)

Petitioner was discharged from therapy on February 2, 2017 because she was seeking a second opinion. The therapist noted that Petitioner had excellent range of motion and strength but moderate grinding of her knee with simple flexion and extension. (PX 4)

Petitioner underwent another Initial Evaluation with the therapy department at Paris Community Hospital on February 7, 2017, having been referred by Dr. Sandercock. The focus was on strengthening. (PX 4)

Petitioner attended physical therapy on February 9, 2017 reporting increased crepitus, popping, and pain after a failed meniscectomy. Petitioner had severe crepitus on flexion /extension of her right knee and generalized tenderness to palpation throughout the knee joint. Petitioner complained of pain with wincing throughout. (PX 4)

Petitioner failed to appear for her February 10, 2017 therapy appointment. (PX 4)

Petitioner attended therapy on February 13, 2017. (PX 4)

Petitioner attended therapy on February 14, 2017. (PX 4)

Petitioner presented to Dr. Sheikh's office on February 14, 2017 for a medication refill. (PX 5)

Petitioner canceled her therapy appointment for February 16, 2017. (PX 4)

At her February 17, 2017 therapy appointment Petitioner reported ongoing symptoms. After performing wall sits, Petitioner reported her knee felt like it wanted to pop. (PX 4)

Petitioner was discharged from physical therapy on February 20, 2017, secondary to no subjective/objective change in status. (PX 4)

Petitioner returned to Dr. Sandercock's office on March 2, 2017. Dr. Sandercock noted that Petitioner had sustained a fall at work on September 6th. She had been treated in Paris, Illinois and undergone corticosteroid injections, viscoelastic supplementation and arthroscopic surgery (12/19/16). Petitioner denied any relief of her pain and rated it at "8/10." She had reached the point where she was requesting a knee replacement. Petitioner told the doctor she'd undergone a left knee replacement and it had served her quite well and it was now time to have the right knee done. He wrote, "She once again informs me that she was having no problems with her right knee prior to the fall at work and now can barely function, in her words, with currently 8/10 pain." Dr. Sandercock performed a physical examination and felt Petitioner was suffering from post-traumatic right knee pain with degenerative joint disease. Noting this was a workman's comp issues, there would need to be authorization. Petitioner just wished to get it done so she could return to work. (PX 6)

On March 2, 2017, Petitioner was evaluated by Dr. James Stiehl of MES Solutions at the request of Respondent for a Section 12 Examination. (RX 5, Resp. 0101-0108) A written report followed. Petitioner reported sustaining a work-related accident on September 6, 2016. She reported working in a freezer unit at Kroger, when she slipped on a non-slip skid surface, falling to her right knee. The MRI suggested a torn medial meniscus of the right knee. Surgery was performed, but the medial meniscus was not removed.

At the time of the examination, Petitioner reported fairly severe pain in her knee with continued chronic problems. Minimal swelling was noted. (RX 5, Resp. 103) She further reported that her knee would actually stick in certain positions and "hurts severely." She reported difficulty walking to the mailbox and back.

Dr. Stiehl performed an AMA Guides Pain Disability Questionnaire, which resulted in a grade 4 with 148 points. (RX 5, p. 103) He indicated that would be characterized as a "severe abnormality."

Dr. Stiehl performed a physical examination, which revealed range of motion 0-130 degrees of flexion. Dr. Stiehl noted that he was unable to get more flexion, as he believed Petitioner was "having internal derangement in the back of [her] knee." Patellar tracking was satisfactory, but crepitus on motion was noted. Provocative testing was negative. It was noted that she had "exquisite posteromedial joint line discomfort" with palpation, as well as evidence of "anteromedial and anterolateral joint line pain that would be consistent with prior arthroscopic procedure." However, he did not see any "significant lateral joint line discomfort." (RX 5, pp. 0101- 0108)

Dr. Stiehl reviewed various medical records provided to him, including a 7.28.13 x-ray and records of her total left knee replacement performed on 2.12.15, He also had notes from 11.17.15 and an x-ray dated 12.22.16 as well as an 11.2.16 MRI. Dr. Stiehl was also furnished information concerning a motor vehicle accident on November 16, 2012 but it didn't involve her right knee. He also had notes from 7.29.13 and 4.30.14 as well as the ER visit of 10.22.16 and records of Dr. Rowe dated 10.26.16 and a 9.30.16 report. Dr. Stiehl also had Dr. Sandercock's records beginning on January 31, 2017 and understood the doctor was now recommending a total knee replacement. (RX 5, pp. 104 – 105)

In his report Dr. Stiehl further noted that "There is a claim that the injury may have occurred on August 23, 2016." (RX 5, p. 104) He further noted the formal date of accident was September 6, 2016 and that Petitioner's examination of September 15, 2016 was normal. (RX 5, p. 104)

According to Dr. Stiehl, Petitioner had evidence of a right medial meniscus tear that day but if it occurred on September 6, 2016 it had not been treated to date. In reviewing the operative report of September 16, 2016 he could not see that a medial meniscectomy had been performed. Regarding causation, he wrote "It is difficult to say if the medical documentation supports a causal relationship between the accident and the September 6, 2016 injury allegedly sustained by Petitioner. He felt Petitioner had a "modest injury to her knee." "She then goes on vacation and then comes back a couple weeks later and now has fairly significant pain." (RX 5, pp. 0106-0108). Dr. Stiehl also indicated that he "would certainly question the workman's compensation injury based on the findings that were made at the time of the injury". He would also "question the fact that there is evidence that she might have actually injured her knee at another time". Therefore, Dr. Stiehl stated "I cannot confirm with probability that there was a meniscal tear caused at this time of the September 6, 2016 incident." Dr. Stiehl went on to note that Petitioner has "modest degenerative arthritis at this time and by her history was having no trouble with her right knee." The MRI scan in November 2016 showed evidence of a torn medial meniscus, which "could have either occurred at home, on vacation, or could have occurred when she tripped and fell on September 6, 2016." Dr. Stiehl felt Petitioner's treatment to date appeared to relate to an injury that occurred at some point in time to her right knee. He felt she needed a repeat arthroscopy as she appeared to have a torn medial meniscus but he didn't feel the injury of September 6, 2016 caused her current problems. He did not feel she was at maximum medical improvement. (RX 5, p. 107)

On March 3, 2017 Petitioner filed her 19(b) Petition. (PX 12)

Dr. Sandercock examined Petitioner on June 1, 2017. She was complaining of "9/10" knee pain along with continuous popping and grinding. She reported going to an IME where it was felt she had a persistent meniscal tear. Dr. Sandercock noted he had planned on proceeding with a total knee replacement based upon Petitioner's complaints; however, based upon the physical findings and IME, the procedure was not authorized. He agreed to perform a follow-up arthroscopy. (PX 6)

On July 7, 2017, Petitioner presented to Sarah Bush Lincoln Health Center for surgical intervention with Dr. Donald Sandercock. (PX 7) The indication for surgery was "knee pain and catching." The pre-operative diagnosis was "meniscal tear right knee." The post-operative diagnosis was "chondromalacia patellofemoral joint with multiple loose bodies right knee." Petitioner underwent a right knee arthroscopy with abrasion chondroplasty of the patella and trochlea and evacuation of loose bodies. Intra-operative findings included Grade 4 chondromalacia of the patella and trochlea. The ACL and medial meniscus were found to be intact. (PX 6; PX 7)

Petitioner followed-up with Dr. Sandercock in July and August 2017. (PX 6) As of August 29, 2017, Petitioner was reporting ongoing problems with her right knee and requesting a total knee

replacement. The doctor noted that Petitioner had hoped the arthroscopy would delay the need for a knee replacement but she had reached the point she was ready to proceed. Dr. Sandercock noted that the physical examination of her right knee revealed range of motion 0-135 degrees with "tremendous crepitus with motion" and pain with meniscal testing. The images showed "tremendous chondromalacia of the anterior medial compartment of the right knee." The diagnosis was osteoarthritis of the right knee. Surgery was to proceed in the near future. (PX 6)

The Arbitration Hearing

Petitioner's case proceeded to hearing on a 19(b) Petitioner on September 19, 2017. Respondent's representative at the hearing was Danielle Montgomery. Witnesses testifying at the hearing included Petitioner, Terri Crain, and Danielle Montgomery. The issues in dispute were accident, causal connection, medical bills, prospective medical care and temporary total disability benefits. (AX 1)

Petitioner testified that in August of 2016, she was employed as the head of the frozen foods department at Respondent's Paris, Illinois store. This job required her to stock shelves, prepare orders, and work in and out of the frozen food freezer. Petitioner testified that on August 23, 2016, she was working alone to unload a delivery truck in the freezer. According to Petitioner, when she went to pull a six foot tall truck skid out of the freezer her feet slid out from underneath her causing her to land on her knees on the stainless steel floor. Petitioner testified that her right knee hit the slick floor. Petitioner testified that the safety strips on the floor were worn down and needed to be replaced as they did not give her any traction. Petitioner also testified that she had reported these worn safety strips to her supervisor at least once every two (2) weeks since she became the head of the frozen department.

Petitioner testified that she noticed "horrible, horrible pain" in her right knee and it took her 2-3 minutes to get up and get her leg straightened out, before she could hobble out of the freezer. She testified that she then immediately reported the accident to her manager, Danielle Montgomery. According to Petitioner, she reported to Ms. Montgomery that she was pulling a skid, fell, and struck her knee on the floor. Petitioner requested that the safety strips be replaced. Petitioner stated that she was asked if she wanted to fill out an accident report, but advised Ms. Montgomery that she did not wish to complete one at that time as she hoped she could work it out.

Petitioner agreed that she didn't hit her left knee on the floor. Petitioner also agreed that she had undergone a left total knee replacement previously.

Petitioner testified that she continued to work after the accident. However, she noticed that her mobility was becoming "more limited." She couldn't squat to get to the lower shelves to stock and she experienced "more pain" when walking. However, she felt she could "walk it off" with time.

Petitioner testified that she had a conversation with Danielle Montgomery on September 1, 2016. The conversation was upstairs in Ms. Montgomery's office. Petitioner believed that Lance, the nighttime stock guy, was also present. Petitioner was called into Ms. Montgomery's office because she was being written up for smoking outside the store while on the clock. Petitioner denied having ever been written up before and she had worked for Respondent about nine years at that point in time. Petitioner recalled that Respondent had guidelines for write-ups but she couldn't recall the details although there were verbal and written warnings before "actions" would be taken. Petitioner then had another conversation with Ms. Montgomery on September 6, 2016 again in her office. Petitioner recalled telling Ms. Montgomery that the safety strips in the freezer still needed to be replaced. She also testified that Ms. Montgomery

inquired into how she was doing and Petitioner told her it was still hurting but she was trying to get through it.

Petitioner testified that she had vacation time coming up in early September and that she sought medical care while off work during that time. When asked why she hadn't sought treatment earlier, she explained that she thought she could walk it off because she isn't a sissy and could usually work through it. Petitioner testified that while on vacation she didn't do anything but sit because she was in pain.

Petitioner denied any injuries to her knee after August 23, 2016. She denied any fall before seeing the doctor on September 14, 2016, the date of her appointment with Dr. Rowe, an orthopedic surgeon. Petitioner testified that Dr. Rowe ordered x-rays and took her off work. She then went to Respondent and talked to the office people as Ms. Montgomery wasn't there. Petitioner also testified that Terri wasn't there to fill out an accident report.

Petitioner further testified that an accident report was filled out on the morning of September 15, 2016. Petitioner testified that she didn't write the date of "8-23-16" on the report; rather, that was done by Respondent's personnel.

Petitioner testified that her next appointment with Dr. Rowe was on September 30, 2016. However, before that visit Petitioner had another meeting with Ms. Montgomery. Petitioner testified that on September 22, 2016 she met with Ms. Montgomery and the union steward, Kayla Hollingsworth, in Ms. Montgomery's office and she was terminated. Petitioner testified that, on September 21st, she had been caught eating in the break room and while on the clock. Petitioner further testified that she was eating because the medicine she was taking was upsetting her stomach and she needed some food. This was her second write-up and she was fired. Petitioner was unaware of any other employee having been terminated after just two write-ups.

Petitioner testified that Dr. Rowe performed knee surgery on December 19, 2016. She then had some physical therapy. However, at the end of December, Dr. Rowe left the hospital and she had to see her family doctor, Dr. Sheikh, for assistance. Petitioner testified that he kept an eye on her swelling and gave her medication and then referred her to another specialist, Dr. Sandercock. She has been treating with him since then. Petitioner underwent a second surgery with Dr. Sandercock in an effort to clean up loose bodies in her right knee. That was performed on July 17, 2017. Dr. Sandercock has kept her on work restrictions through the present.

Petitioner also testified that she is scheduled for a total knee replacement on September 27, 2017.

Petitioner testified that she hasn't worked since being terminated on September 22, 2017.

Petitioner testified that she is not physically capable of working with her right knee in its present condition. She can't sit or stand for very long and her knee gives out on her if she is walking and doesn't use her knee. She described her right knee as "weak, very weak."

Petitioner also testified that she went to the emergency room on October 22, 2016 for follow-up care. She denied being interviewed by several nurses at the time of that visit. She recalled talking to one nurse and then the doctor came in. Petitioner explained that she went to the ER that day because her knee started bruising around the kneecap and she didn't know why. She denied having done anything and was worried about a blood clot. Petitioner disagreed that she told the ER personnel that she hurt her knee on September 9th.

On cross-examination Petitioner agreed that in her nine years with Respondent she averaged about 40 hours per week. She had begun as a meat clerk and was promoted to head of the frozen foods department on November 1, 2015.

Petitioner testified that before August 23, 2016 she had reported problems/issues with the safety strips. She thought she had mentioned it about once every two weeks.

Petitioner estimated that her accident occurred around 11:30 or 12:30, about midway in her shift. She testified that there were no witnesses to the accident. She also testified that only her right leg slid out under her and her right knee hit the safety strip area that was covered with ice. She was wearing nonskid steel-toed tennis shoes with pants. Petitioner estimated the safety strips wee about 12 inches apart and went side to side from the door to the back of the freezer. She described them as thin but gritty. Petitioner denied any other bodily injuries in the accident.

Petitioner testified, on further cross-examination, that she went to Ms. Montgomery after she fell and told her that she had fallen in the freezer after sliding on the floor and that the safety strips needed to be turned in. She recalled telling her that she hit her knee.

Petitioner testified that RX 6 is in her own handwriting except for the date of "8.23.16."

Petitioner agreed that she worked her regular hours between August 21 and September 10, 2011, averaging her usual 40 hours or so. While her job duties didn't change Petitioner did notice she got behind in her work. Petitioner agreed that she didn't ask for a change in her job duties due to her knee. She also agreed that she then went on vacation.

Petitioner agreed that her smoking outside the building while on the clock was against company policy and that she was put on a 30 day probation as a result. She also agreed that her actions on the 21st of September were against company policy.

Petitioner testified that when she went to the ER on October 22, 2016 she did so because she had bruises showing up on her knee. She denied that anything had happened at home like a fall or a strike to her knee. Petitioner testified that when she first injured her knee she had bruising and that the bruising on the 22nd looked the same and she was worried about a blood clot.

Petitioner was asked about her left knee replacement and she explained that she had been diagnosed with arthritis and was having pain, swelling, joint stiffness, and a grinding noise when moving. Before the procedure she had been taking medication and undergone diagnostic testing, therapy and injections. Petitioner testified to a period of slow healing after the knee replacement but that it had worked out very well.

Petitioner denied every being told she had severe arthritis in her left knee. She also denied that anyone since August 23, 2016 has told her she had arthritis in her right knee. When asked if Dr. Rowe had diagnosed her with osteoarthritis of the right knee, she replied, "No." Petitioner acknowledged undergoing treatment for right knee complaints before August of 2016. She recalled that it was right after her left knee replacement and she was putting more stress on her right knee and underwent an injection. Petitioner testified that she thought she had undergone three injections and once her left knee was "built up' her right knee was fine. She only had symptoms of stiffness in her right knee during that time period.

Petitioner acknowledged being on Norco going back to 2014. She has been taking it on a regular basis and she switched from Norco 5 to Norco 10 around January of 2015. Petitioner's left knee replacement was done in February of 2015. Petitioner denied currently taking Norco 10 as she had stopped two months earlier. She agreed that from January of 2015 until April or May of 2017 she was getting her Norco 10 filled every couple of weeks and that she was taking it for her right knee pain. Petitioner also testified that Dr. Rowe increased her from Norco 5 to Norco 10 but that was in January of 2015. No doctor has increased it since August of 2016. Petitioner denied taking any over-the-counter medication for her right knee since August 23, 2016.

Petitioner testified that Dr. Guinto is her family doctor. She could not recall if she had ever seen him for right knee complaints. She did not recall seeing him in July of 2013 for right knee complaints. She did recall undergoing bilateral knee x-rays as they always did both knees when getting x-rays. She did recall complaining to Dr. Rowe about right knee pain and swelling in March of 2016. She recalled telling him about problems with stairs but didn't think she was having problems squatting. If the records show that they are wrong. She might have had problems kneeling with her right knee. She also agreed that she had a popping, grinding noise in her right knee at that time. She explained that if she overused her right knee Dr. Rowe would give her an injection.

Petitioner testified that when treating with Dr. Rowe after August 23, 2016 the only thing he told her was wrong with her knee was that he "went in there and repaired the meniscus." Dr. Sandercock told her the cartilage behind her kneecap was gone and that it could have occurred for a number of reasons. She didn't recall being diagnosed with osteoarthritis.

According to Ms. Crain, around the date of this alleged incident, Petitioner reported to both Ms. Montgomery and herself that the strips in the freezer needed to be replaced because Petitioner did not want anyone to get hurt. However, Petitioner denied that she was hurt and indicated that she did not need to complete an accident report. According to Ms. Crain, it was not until over two (2) weeks after this incident that Petitioner came back into the store during her vacation and asked to complete an accident report. (RX 6) Until then, Ms. Crain had no idea that Petitioner had sustained any type of injury when she fell, as Petitioner had explicitly denied sustaining any injury and failed to report any alleged ongoing complaints about her right knee.

Respondent called Terry Crain, Administrative Manager for Respondent. Ms. Crain testified that she filled out the Injury Report. (RX 6) According to Ms. Crain, around the date of this alleged incident, Petitioner reported to both Ms. Montgomery and herself that the strips in the freezer needed to be replaced because Petitioner did not want anyone to get hurt. However, Petitioner denied that she was hurt and indicated that she did not need to complete an accident report. According to Ms. Crain, it was not until over two (2) weeks after this incident that Petitioner came back into the store during her vacation and asked to complete an accident report. (RX 6) Until then, Ms. Crain had no idea that Petitioner had sustained any type of injury when she fell, as Petitioner had explicitly denied sustaining any injury and failed to report any alleged ongoing complaints about her right knee.

She stated that Petitioner brought in a doctor's slip that said she got hurt on the job, was having surgery, and that she needed to fill out a report. Ms. Crain stated that prior to filling out the Incident Report, Petitioner had reported to temporary store manager (Montgomery) and herself that Petitioner had fallen, the strips needed to be replaced in the freezer, and that she was letting them know because she didn't want anyone to get hurt.

After filling out the Accident Report, Ms. Crain started looking at the calendar and realized that the accident date occurred on August 23, 2016. She crossed out the date of September 6, 2016, and wrote in the date of August 23, 2016.

Ms. Crain also filled out Employee Incident Root Cause Analysis, wherein she stated under Risk Areas that the safety strips needed to be replaced, the safety strips were defective. (RX 6)

Ms. Crain acknowledged that Petitioner told her that she fell, and that the dates which were switched to August 23, 2016, were done in her handwriting.

Ms. Crain was not aware of anything in writing that Respondent had covering termination by the number of CAR's given to an employee before they are terminated.

Danielle Montgomery also testified on behalf of Respondent. Ms. Montgomery was the interim store manager for Respondent's Paris, Illinois store at the time of this incident. According to Ms. Montgomery, Petitioner did not report any type of fall on August 23, 2016. Rather, on August 25, 2016, Petitioner came into her office and stated that two (2) days earlier she had slipped in the freezer and that the strips needed to be replaced. Ms. Montgomery specifically asked Petitioner if she was okay and if it was necessary to complete an accident report, but Petitioner indicated that she was not hurt. Ms. Montgomery testified that Petitioner did not make any statement to Ms. Montgomery that she injured her right knee until Petitioner came into the store during her vacation on September 15, 2016 and asked to complete an accident report.

Ms. Montgomery further testified that it was part of her job to deal with anything that came about administrative-wise. So, she would administer SIR's and CAR's. A "SIR" refers to a significant incident reminder and is more of a verbal warning. A "CAR is a constructive advice record. Ms. Montgomery testified that she had conversations with Petitioner prior to September 1, 2016 regarding smoking while she was supposed to be working. Several associates had seen Petitioner outside smoking during working hours, especially on days when Ms. Montgomery wasn't present at the store. Therefore, Ms. Montgomery gave her a verbal warning to stop. Ms. Montgomery further testified that on September 1, 2016 she watched Petitioner go outside while not on break. She then met with Petitioner and gave her a "CAR" and she was placed on a thirty day probation.

Ms. Montgomery also testified that on September 23, 2016 she gave Petitioner a second "CAR" for a violation of company policy that occurred the day before. Ms. Montgomery explained that Petitioner was observed in the break room eating while still on the clock which is contrary to company policy. Petitioner was indefinitely suspected as of that date.

Ms. Montgomery stated that after terminating Petitioner, she later found out that Petitioner's stomach was hurting which was why she was eating while on the clock.

Ms. Montgomery testified that on August 25th, after her conversation with Petitioner, she placed a call on the "facility hub" to have someone come out and fix the problem with the freezer strips. Ms. Montgomery denied that Petitioner said anything to her about a slip between August 23rd and August 25th. Ms. Montgomery testified that when Petitioner spoke to her on August 25th, she was not advised of a right knee injury. She believed the first time she heard of such an injury was on September 15th while she was on vacation. They then proceeded to fill out the paperwork on that date.

Both Ms. Crain and Ms. Montgomery testified that Petitioner made no complaints about problems with her right knee between August 25, 2016 and when Petitioner left for vacation.

The Arbitrator concludes:

Issue (C): Did Petitioner sustain an accident on August 23, 2016 that arose out of and in the course of Petitioner's employment with Respondent?

Petitioner sustained an accident on August 23, 2016 that arose out of and in the course of her employment with Respondent. Petitioner was working as the head of the Frozen Food Department on August 23, 2016 when she was pulling a six foot truck skid and her feet slid under her and she went down on her right knee. No evidence was presented suggesting that she wasn't in the course of her employment at that time. Furthermore, her accident arose out of her employment as she was engaged in an employment-related risk. While the records are replete with different dates of accident, the description of the incident remained consistent and Danielle Montgomery acknowledged becoming aware of the fall on August 25, 2016. However, Petitioner denied any injury as a result of the fall.

The real question in this case is one of causation.

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

Petitioner failed to prove that her current condition of ill-being in her right knee is causally related to her injury.

The Arbitrator notes that a claimant has the burden of proving by the preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. See, e.g., Parro v. Industrial Commission, 260 Ill.App.3d 551 (1993). 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 (1986).

The courts have established that when a pre-existing condition is aggravated by employment, it may constitute a work-related accident. Peoria Motors v. Industrial Comm'n 92 Ill.2d 260 (Ill., 1982); Cook Co. v. Industrial Comm'n, 68 Ill. 2d 24 (Ill., 1977). However, the claimant bears the burden of showing that the pre-existing condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. Lawless v. Industrial Comm'n, 96 Ill.2d 260 (Ill., 1983); Lyons v. Industrial Comm'n, 96 Ill.2d 198 (Ill., 1983). Additionally, compensation will be denied where an injured employee's health has deteriorated so that any normal daily activity is an aggravation. See Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (Ill., 2003).

The claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been, causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." See St. Elizabeth's Hospital v. Workers' Compensation Commission, 864 N.E.2d 266, 272-273 (5th Dist. 2007). The preponderance of the objective medical evidence in this case reflects that Petitioner's current subjective complaints are the result of a normal and severe degenerative process of her significant pre-existing degenerative right knee condition, as reflected in the pre-accident

diagnostic testing and diagnoses by Dr. John Rowe, and not aggravated or accelerated by the work accident.

Petitioner testified to "horrible, horrible" pain in her right knee immediately after the accident and she stated that it took two to three minutes for her to get up and straighten out. While she testified that she immediately reported it to Ms. Montgomery, the Arbitrator finds the testimony of Ms. Montgomery more credible as to when Petitioner informed her of the fall -- to wit, two days later. More importantly, and regardless of whether that conversation was held on August 23rd or 25th, Petitioner denied any injury requiring the completion of an accident report. Her ability to work full duty with no restrictions or assistance for another 40 hour week, her lack of need for immediate medical attention and/or care, and her silence regarding any knee injury or problems associated with the fall are inconsistent with her testimony regarding how horrible her pain was.

While Petitioner testified to a conversation with Ms. Montgomery on September 1, 2016 regarding her smoking outside on company time and that "Lance" was present for that meeting, company records confirm that the meeting took place on October 1, 2016 and not September 1, 2016. Petitioner's testimony on that issue was wrong.

After the first conversation with Ms. Montgomery (at which point Petitioner's concern appeared to be the strips on the floor and not her right knee) Petitioner had another conversation with Ms. Montgomery on September 6, 2016. At that time Petitioner told Ms. Montgomery the strips still needed to be repaired/replaced. Something was said about the fall because September 6, 2016 would later be used as the date of accident when Petitioner completed an accident report on September 15, 2016. However, based upon the credible testimony of Ms. Crain and Ms. Montgomery, Petitioner said nothing about a right knee injury associated with the fall at the time of their conversation on the 6th.

Petitioner also admitted that she was on vacation the week of September 11-17, 2016. It was not until she was on vacation that Petitioner first sought medical treatment and decided to complete an accident report. That was three (3) weeks after the accident. That Petitioner truly injured her right knee in the fall becomes more questionable in light of the fact Petitioner did not seek medical treatment until three (3) weeks after the accident and also after being disciplined by Respondent in the days before she sought such medical treatment. On September 1, 2016, Petitioner was placed on probation after she was observed to be outside the store smoking while on the clock. Ms. Montgomery testified that Petitioner had already been warned about taking smoke-breaks while on the clock. Petitioner admitted that she did take this smoke-break outside while on the clock and that she was aware that it was against store policy. As a result of this infraction, Petitioner was placed on 30-day probation and advised that her failure to comply would result in further disciplinary action up to and including indefinite suspension.

Credibility of a self-interested witness is always essential to addressing the weight of the evidence. While the concept of truthfulness is always important, it becomes absolutely critical once Petitioner's credibility is questioned. There is evidence in this record to indicate Petitioner's credibility is in question. Workers' compensation benefits have been denied by the Commission and affirmed by the Courts in numerous instances when the claimant's credibility was suspect and contemporaneous medical histories conflicted with and/or failed to corroborate the claimant's testimony. See Elliott v. Industrial Commission, 303 Ill.App.3d 185, 707 N.E.2d 228 (1st Dist., 1999); McRae v. Industrial Commission, 285 Ill.App.3d 448, 674 N.E.2d 512 (5th Dist., 1996); Banks v. Industrial Commission, 134 Ill.App.3d 312, 480 N.E.2d 139; Luby v. Industrial Commission, 82 Ill.2d 353, 412 N.E.2d 439 (1980). Furthermore, when an Arbitrator finds that a petitioner has not been truthful on a particular issue, the Arbitrator may then find Petitioner is not credible as to other issues. See, Parro v. Industrial Commission, 167 Ill.2d 385,

657 N.E.2d 882, 997 (1995) ("It was appropriate for the Commission to conclude that if the claimant's testimony concerning her consumption of alcohol lacked credibility, so too did her explanation of the immediate cause of the accident.").

Not only were there inconsistencies between the testimony of Petitioner and Respondent's witnesses but the Arbitrator cannot overlook Petitioner's less than forthright representations/history to Dr. Sandercock. At the initial visit with the doctor, she denied any follow-up treatment after her December 2016 surgery with Dr. Rowe. That was untrue – she saw his physician's assistant and underwent therapy. She also told Dr. Sandercock that she was having no problems with her right knee prior to her fall at work. That statement is also contradicted by the medical records pre-dating her accident.

Petitioner attempted to downplay her extensive history of right knee complaints that pre-dated this incident. She alleged that her prior complaints were only around the time immediately after her total left knee replacement and were successfully treated by a few injections. She claimed that once she got her left knee built up, her right knee was "fine." She stated that the only symptom she was having ptr-accident was "stiffness." She denied that she had ever been advised that she had osteoarthritis in her knees. However, Petitioner's testimony is completely contradicted by the extensive pre-accident medical records. As will be shown, these medical records reflect that Petitioner had a lengthy history of ongoing bilateral knee complaints dating back to July of 2013. (RX 1, 2, 3, and 4).

In July of 2013, Petitioner presented to Dr. Guinto Mert at the Family Medical Center with a history of pain around the right knee area "for quite some time." (RX 1, Resp. 0002) She complained that the pain was "quite worse lately" and that she could "feel the grinding sensation every time she moves around." She also complained of the knee being stiff and painful, which worsened as the day progresses. The physical examination confirmed tenderness over the right knee, as well as grinding sensation on flexing and extending. She was referred to Dr. Rowe, an orthopedist.

In April of 2014, Petitioner presented to Dr. Rowe with complaints of bilateral knee pain. (RX 3, Resp. 0074). It was noted that she had "insidiously progressive bilateral knee pain," which caused her to have difficulty getting in and out of chair, going up and down stairs, and sitting in one position for an extended period of time. Upon review of the x-rays, Dr. Rowe noted that Petitioner had patella femoral arthritis of the right knee. Dr. Rowe diagnosed Petitioner with moderately severe bilateral patella femoral arthritis due to malalignment and hypertrophic trochlea and external torsion of the femurs.

From April of 2014 through June of 2015, Petitioner underwent two (2) surgeries for the osteoarthritis in her left knee. (RX 2, Resp. 0138-0150). Diagnostic studies and intra-operative notes confirmed that Petitioner was suffering from "disabling patellofemoral arthritis of the left knee." (RX 2, Resp. 0141-0143)

As Petitioner was concluding treatment for her arthritic left knee, which eventually required a total knee replacement, Petitioner's complaints regarding her right knee again resurfaced. In June 2015, Petitioner reported "significant crepitus and intermittent swelling" of the right knee. (RX 3, Resp. 0075) Dr. Rowe again noted that Petitioner has patella femoral arthritis in the right knee. For this degenerative arthritis in the right knee, Dr. Rowe provided Petitioner a cortisone injection.

In November of 2015, Petitioner again returned to Dr. Rowe with continued complaints of significant grind and compression and significant effusion of her right knee. (RX 3, Resp. 0076) Yet again, Dr. Rowe noted that Petitioner has "known right knee patellofemoral degenerative arthritis." Due

to the prior success of the cortisone steroid injections, Dr. Rowe performed another injection. However, at this visit, Dr. Rowe specifically discussed options of future treatment of her right knee, which included "patellofemoral arthroplasty versus total knee arthroplasty" in order to treat her right knee patellofemoral arthritis.

Petitioner's significant right knee arthritis continued to progress over the next several months. In March of 2016, Petitioner again returned to Dr. Rowe with complaints that her right knee was getting "progressively worse". (RX 3, Resp. 0078) Petitioner complained of increasing pain, swelling, and difficulty with stairs, squatting, and kneeling as a result of her right knee condition. Dr. Rowe noted that Petitioner had difficulty toe walking and squatting on the right knee. The physical examination of the right knee revealed positive effusion, severe patellofemoral grind, and crepitus with hypomobility and significant guarding atrophy of the quadriceps muscle. Yet another cortisone steroid injection was performed on Petitioner's right knee. Dr. Rowe specifically noted that her right knee is experiencing increasing symptoms referable to her severe patellofemoral arthritis of the right knee. At this visit, approximately six (6) months before Petitioner's incident at work, Dr. Rowe's records are replete with subjective complaints and objective findings of severe patellofemoral arthritis of Petitioner's right knee. Dr. Rowe was already considering a total right knee replacement due to the extensive degenerative arthritis in Petitioner's right knee, which was the same condition he had already treated in Petitioner's left knee.

In addition, the pharmacy records reflect that Petitioner's bilateral knee complaints were so significant that she was on a steady diet of Norco 5 and eventually Norco 10 prescriptions from April 2014 through April 2017. (RX 1, Resp. 0003-0050; RX 2, Resp. 0055-0072; RX 4, Resp. 0080-0100) From April 30, 2014 through December 18, 2014, Petitioner regularly filled her prescription for Norco 5/325 mg, which was prescribed to her by Dr. Guinto Mert for her right knee pain complaints. (RX 1, Resp. 0002-0004) After seeing Dr. Rowe for her bilateral knee complaints in June 2014, he took over the prescribing of the Norco 5/325 mg for Petitioner's bilateral knee complaints. (RX 1, Resp. 0006-0017)

In December of 2014, Petitioner's Norco prescription was increased from 5 mg to 10 mg. (RX 1, Resp. 0018) From January 2015 through August 18, 2016, Petitioner refilled a prescription for Norco 5 or Norco 10 on 33 separate occasions. (RX 1, Resp. 0018-0050; RX 2, Resp. 0067-0137; RX 4, Resp. 0080-0090) On average, Petitioner was receiving a prescription for Norco 10 which included 70 tablets to be taken over a 14 day period. Sometimes Petitioner received 150 tablets of Norco 10, which was to be taken over a 30 day period. Petitioner admitted that she was receiving these prescriptions for her ongoing right knee pain both before and after this incident.

As shown, Petitioner's medical records reflect a lengthy history of ongoing complaints related to Petitioner's right knee from April 2014 through March 2016. In fact, Dr. Rowe had already discussed Petitioner's need for a total right knee replacement in November 2015. For at least two (2) years before this incident, Petitioner's diagnosis of severe patellofemoral arthritis of the right knee remained the same, while her condition continued to deteriorate and cause her significant complaints of pain, swelling, grinding, and difficulty with mobility. Her condition was so severe that Petitioner was unable to manage her pain complaints with a steady regimen of Norco 5 and/or Norco 10, which was regularly refilled since April 2014. This regimen remained unchanged after the incident of August 2016.

As noted above, the claimant herein bears the burden of showing that a pre-existing condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. Lawless v. Industrial Comm'n, 96 Ill.2d 260 (Ill., 1983); Lyons v. Industrial Comm'n, 96 Ill.2d 198 (Ill., 1983). In this case, Petitioner's pre-accident

medical documentation from 2014 through 2016 shows continued significant deterioration of her right knee due to severe, progressive patellofemoral arthritis of the right knee. There is no objective evidence that Petitioner's current complaints are related to the August 2016 fall.

The objective evidence, findings on physical examination, and diagnoses were the same before and after this fall. The conservative treatment with pain medication, as well as the recommended total knee replacement surgery were all previously discussed in the year before this incident. There is no objective evidence that this fall exacerbated Petitioner's underlying condition. Rather, the evidence reflects the continued progression of the natural, yet severe, degeneration of her right knee due to arthritis.

The Arbitrator further notes that Petitioner's subjective complaints regarding her right knee are exactly the same pre- and post-incident. Despite Petitioner's testimony that her only pre-accident complaints related to her right knee were for "stiffness", the records paint quite a different picture. In July 2013, Petitioner complained of worsening pain in the right knee, as well as a grinding sensation in her knee "every time she moves around". (RX 1, Resp. 0002) In April of 2014, Petitioner complained of insidiously progressive bilateral knee pain, which caused her problems getting in and out of chairs, going up and down stairs, and sitting in one position for an extended period of time. (RX 3, Resp. 0074) These right knee symptoms continued to progress, as noted in the June 26, 2015 note of Dr. Rowe which stated that Petitioner's right knee complaints now included pain, significant crepitus, as well as intermittent swelling. (RX 3, Resp. 0075) These same complaints were noted in the November 17, 2015 and March 22, 2016 notes from Dr. Rowe. (RX 3, Resp. 0076-0077) When compared to Petitioner's post-incident medical records, the subjective complaints are identical: pain, swelling, crepitus, and difficulty with mobility, including stairs, standing, and sitting. (RX 1, 2, 4, 5, and 6) The fact that Petitioner's pre-accident subjective complaints are identical to her post-accident subjective complaints only further supports a finding that Petitioner has failed to prove that her current condition of ill-being is causally related to this incident.

The Arbitrator is aware that Dr. Sandercock opined that Petitioiner's fall caused an exacerbation of her underlying arthritic problem. (PX 6) However, there is absolutely no evidence that Dr. Sandercock was aware of the extent of Petitioner's significant history of prior right knee complaints. His records are devoid of any proof that he was aware of the fact that Dr. Rowe had already discussed Petitioner's need for a total right knee replacement in November 2015, which was less than one (1) year before this incident. There is no evidence that Dr. Sandercock was aware that Petitioner had undergone multiple injections and continued a steady regimen of Norco prescriptions in an attempt to manage the severe right knee pain she was experiencing in the year before this incident. There is no evidence that Dr. Sandercock ever had the opportunity to review the pre-accident records regarding Dr. Rowe's ongoing treatment of Petitioner's right knee condition. As such, Dr. Sandercock's opinions on causation are not given any weight.

Similarly, while Dr. Rowe's notations in his records suggest an exacerbation of Petitioner's pre-existing right knee condition, the doctor was unaware that Petitioner had continued to work for three weeks prior to seeking any treatment and that she had denied any injury related to her fall up until the time he came to see her. Dr. Rowe did not opine that Petitioner's "possible" medial meniscus tear was work-related. He used only the word "may/might which does not equate to a "reasonable degree of medical and surgical certainty."

Even if the Arbitrator were to overlook the extensive history referenced above, the

Arbitrator notes that the emergency room records of October 22, 2016 reflect the existence of some intervening incident. (RX 2, Resp. 0151-0156) This is the first time that Petitioner is seen at the emergency room after the work incident and the records indicate that she presented with acute injuries of bruising, swelling, and tenderness. (Id., Resp. 0151) There is no reference in the records from Dr. Rowe that Petitioner had any significant bruising on her right knee between August and September 2016. (PX 1) However, she presented to the emergency room two (2) months after the incident, and it is noted that there is "this morning new bruising to the right knee and pain." (RX 2, Resp. 015). The nurses' notes reflect that the context of her right knee complaints are a "problem was sustained at home, resulted from an unknown cause." Petitioner was to follow up with her primary care doctor but failed to do so. Based upon these records, there is some new issue with Petitioner's right knee that appears to have no relationship to any fall at work on August 23, 2016. While Petitioner denied the accuracy of this history, she took no steps to correct it, and, given her faulty recollection regarding the dates of conversations and accident dates themselves, may have a faulty recollection on this matter also.

Based upon the foregoing, the Arbitrator finds that Petitioner has failed to meet her burden of proof regarding causal connection. Petitioner's claim for compensation is denied and no benefits are awarded.

Issue (J): **Were the medical services that were provided to Petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?**

Issue (K): **Is Petitioner entitled to any prospective medical care?**

Issue (L): **What temporary benefits are in dispute (TTD)?**

Based upon her liability determination, the foregoing issues are moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Richard Scardina,

Petitioner,

vs. NO: 14 WC 03995

Metro South Medical Center,

Respondent.

18IWCC0323

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 25, 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.

18IWCC0323

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 $9,000.00. 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: MAY 24 2018
o041918
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

SCARDINA, RICHARD
Employee/Petitioner

Case# **14WC003995**

METRO SOUTH MEDICAL CENTER
Employer/Respondent

18IWCC0323

On 10/25/2017, 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 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1455 LAW OFFICES OF BOZICH & KORN
BRUCE M BOZICH
188 CIRCLE RIDGE DR
BURR RIDGE, IL 60527

0560 WIEDNER & McAULIFFE LTD
MARY C SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Richard Scardina
Employee/Petitioner

v.

Metro South Medical Center
Employer Respondent

Case # 14 WC 03995

Consolidated cases:

18IWCC0323

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **September 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 30, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,174.52**; the average weekly wage was **$1,349.51.**

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

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

ORDER

The Arbitrator finds that Petitioner proved by the preponderance of the evidence that his current condition of ill-being **is causally related to his work injury of May 30, 2013.**

Respondent shall pay Petitioner Temporary total disability benefits of **$899.67**/week for **9 and 6/7** weeks, commencing **July 14, 2017 through September 21, 2017**, as provided in Section 8(b) of the Act.

Respondent is **not liable** for any unpaid prescription costs.

The Petition for **Penalties and Attorney fees is denied.**

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

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

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

Signature of Arbitrator

10/24/2017
Date

ICArbDec19(b)

OCT 25 2017

FINDINGS OF FACT

The parties stipulated that on May 30, 2013, Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent. The parties further stipulate that Respondent approved surgery, on the eve of trial, recommended by the treating physician, Dr.Redondo consisting of right knee arthroscopy with poly exchange lateral release. (T. 13)

The issues in dispute involve whether Petitioner's current condition of ill-being is causally related to his work injury of May 30, 2013, whether Respondent is liable for certain prescription medications and whether Petitioner is entitled to total temporary disability benefits from July 14, 2017 through September 21, 2017 plus two additional days of total temporary disability benefits allegedly accrued prior to July 14, 2017. (T. 5) Petitioner filed a petition for penalties and attorney fees pursuant to Sections 16(k), 19(l) and 16 of the Act. Petitioner's petition for penalties and attorney fees is based, in part, upon Respondent's failure to offer vocational rehabilitation services, however, at trial, Petitioner stated the he was not seeking vocational rehabilitation services. (T. 7)

On May 30, 2013, Petitioner, Richard Scardina, sustained an accidental injury to his right knee while working as painter/maintenance person for Respondent, Metro South Hospital. Petitioner was 49 years old at the time of his injury. Petitioner testified that his work duties included painting, scaffolding work, ladders, kneeling, squatting, rolling the walls out, unplugging toilets, changing light bulbs and changing filters. (T. 17). Petitioner reported on May 30, 2013, he rolled his right ankle hyperextending his right knee while walking on the roof. (T. 18).

Petitioner underwent an initial MRI of the right knee which showed a medial meniscus tear, degenerative changes, and a partial ACL tear. Petitioner underwent surgery on July 15, 2013. (T. 21-22). Petitioner returned to work following the right knee arthroscopy on September 22, 2013. After returning to work for Respondent, Petitioner secured other employment with South Suburban Hospital. (T. 60). Petitioner continued to work until his right knee replacement surgery, which occurred on January 13, 2015. (T. 32).

Petitioner testified that he has not returned to work since his right knee replacement surgery. (T. 32). Petitioner testified that due to a buildup of scar tissue, he underwent two subsequent surgeries to remove scar tissue. (T. 36).

On July 29, 2016, Petitioner returned to his treating physician, Dr. Redondo, who recommended Petitioner continue home physical therapy, wear a knee brace and attend pain management. Dr. Redondo indicated that if Petitioner does not improve in the next 4-6 weeks, he will place Petitioner at maximum medical improvement. (PX 1)

On July 28, 2016, Petitioner returned to Dr. Redondo complaining of severe pain. At that time, Dr. Redondo provided Petitioner three treatment options. Petitioner could live with his current condition; Petitioner could undergo another scar tissue resecting procedure or Petitioner could undergo a complete revision of the prior surgery and a rebalancing of the right knee. Dr. Redondo recommended Petitioner live with his current condition. (PX 1)

On January 26, 2017, Petitioner was evaluated by Dr. Branovacki, one of Dr. Redondo's partners. Dr. Branovacki thought that Petitioner may have RSD and nerve damage. Dr. Branovcki did not recommend surgical intervention finding that Petitioner would not benefit from surgical intervention. (PX 1)

On July 26, 2017, Petitioner returned to Dr. Redondo. At that time, Petitioner indicated that he wished to proceed with the debridement with possible polyethylene exchange and lateral release surgery. Dr. Redondo recommended the surgery and he renewed Petitioner's 25 pound lifting restrictions. (PX 1)

At trial, Petitioner testified he did not receive income from any other sources. (T. 47) Petitioner. Petitioner subsequently testified that he earns extra money making "gravy" or red sauce for pasta. (T. 49) Petitioner testified that he supplies his gravy to Honey Baked Ham and has been doing so for the past seven to eight years. (T. 49). Petitioner testified that he drops off batches of raviolis and sausages to Chicagoland Hams who sells them for him. Petitioner testified he does not report the income to the IRS. (T. 53) Petitioner testified his mother, who does not drive, works at Chicagoland Hams three days a week. Petitioner testified he drops off and pick up his mother from Chicagoland Hams and that his works 5 hours shifts usually on Thursdays, Fridays and Wednesdays. (Tr. 68) Petitioner testified that he hangs out with his mother at Chicagoland Hams but he does not work for Chicagoland Hams or receive a paycheck from Chicagoland Hams. (T. 51, 52)

Testimony of Brett Furlong:

Brett Furlong, field operations manager of the Robison Group, conducted surveillance of Petitioner. Mr. Furlong surveilled Petitioner on May 15, May 16, May 23, May 24, and June 2

of 2017. (79). Mr. Furlong's surveillance included video which was submitted into evidence without objection. Mr. Furlong testified the posted shore hours of Chicagoland Ham was 10:00 a.m. to 5:00 p.m.

On Tuesday, May 16, 2017, Petitioner was seen arriving, alone, at Chicagoland Ham store at approximately 10:00 a.m. Petitioner exits his vehicle and enters the store. Video surveillance captured shows Petitioner assisting or preparing of food with a store staff member at 12:05 p.m. At approximately 4 p.m. Petitioner departed the store, alone. (RX 1).

On Tuesday, May 23, 2017, a few minutes before 10 a.m. Petitioner arrives at the store, alone, and opens the back of his vehicle to remove two cases of bottled water. Petitioner carries the bottle water into the store. At approximately 2:32 p.m., Petitioner was seen exiting the back door of the store and walking to another unit of the shopping center, unlocking the unit, and entering the unit. Thereafter, Petitioner exits the unit, locks it, and returns to the store caring a box. Petitioner remains at the store until approximately 5:00 p.m. (RX 1).

On Wednesday, May 24, 2017, at approximately 10:00 a.m., Petitioner arrives at the store, alone. Video footage taken throughout the day shows Petitioner working at the front of the store, sorting papers, talking on a phone and sorting or placing labels on packages. (RX 1).

On Friday, June 2, 2017, at approximately 9:53 a.m. Petitioner arrives at Chicagoland Ham store. Petitioner is seen getting out of his car and trying to open a locked door. Thereafter, Petitioner returns to his vehicle until 10:03 a.m., when an unidentified female approaches the store and opens the door. Petitioner exits his vehicle and enters the store. At that time, another female, walks to the back of the store, which Petitioner identified as his mother. (T. 92) Petitioner stayed at the store until approximately 5:00 p.m. (PX 1)

Following the testimony of the investigator in this case, Petitioner was called a witness to rebut the testimony of Mr. Furlong. Petitioner testified that a case of water he carried weighed approximately 15 pounds. (T. 120). In explanation of why he was carrying water into the store, Petitioner explained that he had been at Costco and the owners needed a case of water, "so I grabbed a case of water." (T. 124). Petitioner admitted being behind the counter making himself a sandwich. (T. 120). Petitioner testified that on occasion he spends five, six, or seven hours at the store because he is "bored, nothing to do." (T. 120).

The Arbitrator did not find the testimony of the Petitioner to be credible.

CONCLUSIONS OF LAW

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

The employee bears the burden of proving by a preponderance of the evidence all the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n , 398 Ill. App. 3d 858, 867 (2010).* Among the elements that the employee must establish is that his condition of ill-being is causally connected to his employment. *Elgin Board of Education U-46 v. Workers' Compensation Comm'n , 409 Ill. App. 3d 943, 948 (2011).*

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

Among the elements that the employee must establish is that his condition of ill-being is causally connected to his employment. *Elgin Board of Education U-46 v. Workers' Compensation Comm'n , 409 Ill. App. 3d 943, 948 (2011).* Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission* , 64 Ill. 2d 244,356 N.E. 2d 28 (1976). It is well established that an accident need not be the sole or primary cause as long as employment is a cause of a claimants' condition. *Sisbro, Inc. v. Industrial Comm'n* , 207 Ill.2d 193, 205 (2003).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that Petitioner's current right knee condition is causally related to his work injury of May 30, 2013. Respondent stipulated that Petitioner sustained an accidental injury to his right knee on May 30, 2013. On the eve of trial, Respondent approved the surgery recommended by Dr. Redondo. (T. 13) Respondent did not proffer any evidence disputing that Petitioner's current condition of ill-being was not caused his work accident of May 30, 2013.

WITH RESPECT TO ISSUE (J) WERE THE MEDICAL SERVIES PROVIDED TO PETITIONER PROVIDED TO PETITIONER REASONALBE AND NECESSARY AND, IF SO, HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES

Petitioner claims that Respondent is liable to reimburse Petitioner for prescriptions paid out of his pocket. Petitioner must prove by a preponderance of the credible evidence all elements of his claim. *Hannibal, Inc. v. Industrial Commission* , 38 Ill.2d 483 (1967) The

Arbitrator finds that Petitioner failed to prove the prescriptions were reasonable and necessary medical services. Petitioner did not submit evidence identifying the specific prescriptions Petitioner claims that Respondent should have paid and receipts showing Petitioner had paid the costs of the prescriptions. (T. 64) When asked to the amount of money paid for prescriptions, Petitioner testified "couple hundred dollars." (T. 57). An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994). For treatment of an employee's workplace injury to be compensable, under workers' compensation laws, Petitioner must establish the treatment is necessitated by the work injury and not some other cause or condition. *Hansel & Gretel Day Care Center v Industrial Commission*, (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244. Petitioner failed to submit any evidence identifying the prescriptions obtained, the cost of the prescriptions, and that the prescriptions were necessary because of his work injury.

WITH RESPECT TO ISSUE (K). WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY BENEFITS. THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is seeking temporary total disability benefits from July 14, 2017 through September21, 2017 plus an additional two days of TTD benefits from prior to July 14, 2017. (Arb. Ex.#1)

When a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized (*i.e.* whether the claimant has reached maximum medical improvement). *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n, 236 Ill. 2d 132, 142, 923 N.E.2d 266, 271, 337 Ill. Dec. 707 (2010).* Once an injured employee's physical condition stabilizes, he is no longer eligible for TTD benefits. *Archer Daniels, 138 Ill.2d at 118, 561N.E.2d at 627* . The duration of TTD is controlled by the claimant's ability to work and his continuation in the healing process. *City of Granite City v. Industrial Comm'n, 279 Ill. App. 3d 1087,1090, 666 N.E.2d 827, 828, 217 Ill.Dec. 158 (1996).*

The fact that a claimant has returned to work, in some capacity, *may* be relevant to whether and to what extent the claimant's condition has stabilized. To this extent, it may well be appropriate to consider the type of work being performed, hours worked, and any income earned, all to ascertain whether the claimant's condition has stabilized. See *Freeman United Coal Mining Co. v. Industrial Comm'n, 318 Ill. App. 3d 170, 178, 741 N.E.2d 1144, 1150, 251 Ill. Dec. 966 (2000).* The factors to be considered in determining whether a claimant has reached maximum

medical improvement include a release to return to work, with restrictions or otherwise, and medical testimony or evidence concerning claimant's injury, the extent thereof, the prognosis, and whether the injury has stabilized. *City of Granite City v. Industrial Comm'n, 279 Ill. App. 3d 1087, 666 N.E.2d 827, 217 Ill.Dec. 158 (1996).* In determining TTD benefits, the issue is whether claimant's condition has stabilized to the extent that Petitioner is at MMI, not whether Petitioner was performing some work. See *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n.* 383 Ill. Dec. 184; 14 N.E.3d 16; 2014 Ill. App. LEXIS 454; 2014 WL 2895455 (3rd Dist. 2014)

The Arbitrator finds that Petitioner's condition had not stabilized. On July 26, 2017, Dr. Redondo recommended surgery, which Respondent approved. Based upon surgical recommendation and Respondent's authorization for surgery, Petitioner's condition was not stabilized on July 14, 2017. Therefore, the Arbitrator finds that Petitioner has proven by the preponderance of the credible evidence that he was entitled to TTD benefits from July 14, 2017 through September 21, 2017.

The Arbitrator finds that Petitioner failed to prove that he was entitled to two additional days of TTD, which Petitioner claimed he was not paid for prior to July 14, 2017. Respondent's Exhibit 6 shows that Petitioner was paid TTD benefits from May 23, 2017 through May 26, 2017, in the amount of $514.11. This is the amount Petitioner claimed he was not paid. (T. 41) Accordingly, the Arbitrator finds that Petitioner failed to prove he was entitled to TTD benefits for the two days prior to July 14, 2017.

The Arbitrator does not find Petitioner's testimony credible regarding the nature of the work performed at Chicagoland Hams. Petitioner originally testified that he would drop off and pick up his mother at the store. The video surveillance contradicted Petitioner's testimony and showed Petitioner was at the store far more often than Petitioner testified on direct examination. The video surveillance showed Petitioner was not merely dropping off and picking up his mother. However, the appropriate inquire is whether Petitioner's condition had stabilized, not whether he was performing some work. The factors to be considered in determining if one's condition has stabilized includes determining whether Petitioner had been released to return to work, the nature of the restrictions, if any, type of work performed, the hours worked and the income derived from the work. Based upon the various factors, the Arbitrator finds that Petitioner's condition had not stabilized.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Penalties imposed under section 19(l) are in the nature of a late fee. The award of section 19(l) penalties is mandatory if the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay. The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. The employer bears the burden of justifying the delay, and its justification is sufficient only if a reasonable person in the employer's position would have believed the delay was justified.

The standard for awarding penalties and attorney fees under sections 19(k) and 16 is higher than the standard for awarding penalties under section 19(l) because sections 19(k) and (16) require more than an "unreasonable delay" in payment of benefits. For the award of penalties and attorney fees under sections 19(k) and 16, it is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. Instead, penalties and attorney fees under sections 19(k) and 16 are intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose. In addition, while section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under sections 19(k) and 16 is discretionary.

In his Petitioner for Penalties and Attorney Fees Petitioner claims that Respondent failed to offer vocational rehabilitation, continuously in a timely manner refused to authorize and pay for necessary physical therapy and pain management and repeatedly delayed in the payment of TTD benefits from 6 to 14 days during the last 12 months.

The Parties stipulated that Petitioner was not at maximum medical improvement. On the eve of trial, Respondent approved the surgery recommended by Petitioner's physician. Because Petitioner was not at maximum medical improvement Respondent was not required to provide Petitioner vocational rehabilitation services. Regarding delays in authorizing and paying for treatment and TTD benefits, the Arbitrator finds that Petitioner failed to prove that Respondent's conduct was deliberate or the result of bad faith or improper purpose and, therefore, Petitioner's penalties pursuant to Sections 19(k) and 16 are denied. The Arbitrator also denies penalties pursuant to Section 19(l) because Petitioner failed to prove that Respondent did not act without good or just cause. he was entitled to Section 19(l) penalties.

Section 19(l) provides for the imposition of a penalty where the employer "without good and just cause," fails to pay or delays payment of TTD benefits. The Arbitrator finds that this is not remotely a penalties case. As noted above, it is a well-established principle that awards cannot rest on speculation and conjuncture, and the same is true of an award for penalties. In this case, Petitioner is seeking penalties for delays in the issuance of TTD benefits for various times, without any specificity as to which checks or dates payments were late, for how long. (T. 43).

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

Roger Clemons,
Petitioner,

vs. NO: 15 WC 39931

State of Illinois/ Department of Corrections,
Respondent.

18IWCC0324

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 September 27, 2017, is hereby affirmed and adopted.

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

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

DATED: MAY 24 2018
o050318
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLEMONS, ROGER
Employee/Petitioner

Case# **15WC039931**

ST OF IL DEPT OF CORRECTIONS
Employer/Respondent

18IWCC0324

On 9/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0000 ASSISTANT ATTORNEY GENERAL
JOSEPH P 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 SERVICES
BUREAU OF RISK MANGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9209

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

SEP 27 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
NATURE AND EXTENT ONLY

Roger Clemons
Employee/Petitioner

v.

State of Illinois/Dept. of Corrections
Employer/Respondent

Case # 15 WC 39931

Consolidated cases: N/A

18IWCC0324

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Bloomington**, on **8/25/16**. By stipulation, the parties agree:

On the date of accident, **8/6/15**, 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 **$77,819.56**, and the average weekly wage was **$1,496.53**.

At the time of injury, Petitioner was **52** 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 **$4,418.52** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,418.52**.

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

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$755.22**/week for a further period of **71.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **35% loss of use of the right hand**.

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.

Michael K. Nowak, Arbitrator

9/18/17
Date

ICArbDecN&E p 2

SEP 27 2017

FINDINGS OF FACT

Petitioner is a 53 year old, right hand dominant correctional supply officer at the Lincoln Correctional Center. He has worked there since 1993. He currently oversees the kitchen. Petitioner is right hand dominant.

On August 6, 2015 Petitioner was in the walk-in freezer with his inmate helper breaking down a pallet of meat. When he pulled on some shrink wrap, it unexpectedly gave away, causing him to fall backwards, landing on his right wrist. He was immediately taken by ambulance to the Abraham Lincoln Hospital emergency room where X-rays showed fractures of the distal right radius and ulna. (PX 1, p.3) These were comminuted fractures with an impacted fractured fragment and a minimally displaced ulnar styloid process fracture. (PX 1, p.4) He was discharged and referred to Dr. Lawrence Li. (PX 1, p.5)

Petitioner saw Dr. Li on August 6, 2015 giving a history of a slip and fall in a freezer earlier that day. (PX 2, p.6) That same day, Dr. Li diagnosed a right angulated displaced comminuted four part distal radius fracture and recommended an open reduction internal fixation right wrist surgery. On August 7, 2015 Dr. Li performed the ORIF procedure and released the flexor carpi radialis tendon. He used a plate and several corticol screws proximally and fixed the position of the plate with distal locking screws. (PX 2, pp.2-3)

On September 10, 2015, Dr. Li permitted Petitioner to return to work with a ten pound restriction for his right hand. (PX 2, p.62) On October 7, 2015 Petitioner began to complain of numbness in his fingers during physical therapy. (PX 2, p.98) On November 4, 2015, Petitioner was still in occupational therapy and his assessment that day included continuing mild numbness in his right thumb, index and middle fingers, with weakness in grip strength and 3 point pinch. (PX 2, p. 144)

Petitioner saw Dr. Li in follow-up on November 5, 2015. Dr. Li noted that he had made good progress with extension but that his flexion had not improved much. Dr. Li also noted that Petitioner had had numbness and tingling in his thumb and first 2 fingers since his injury. Dr. Li diagnosed residual loss of wrist function and right carpal tunnel syndrome "due to distal radius fracture". Dr. Li ordered an EMG/NCV study that day. (PX 2, pp. 149-150)

Petitioner underwent the nerve study on November 16, 2015. (PX 3) The study showed severe median neuropathy at the right wrist. His left wrist had no current evidence of a similar lesion. (PX 3, p.5)

On November 23, 2015 Dr. Li recommended a right carpal tunnel release, stating, "Right wrist post traumatic Carpal Tunnel Syndrome. The injury at work that caused the fracture is now causing severe Right Carpal Tunnel Syndrome. It is my opinion to a reasonable degree of medical certainty that the work injury is the indirect cause of the carpal tunnel syndrome." (PX 2, p. 172)

On January 5, 2016 Dr. Li performed a right carpal tunnel release. (PX 2, p.5) Petitioner returned to restricted duty work two days later. His occupational therapy was completed on March 2, 2016. (PX 2, pp. 249-250)

Respondent had a records review for permanent partial impairment rating purposes, performed by Dr. David Anderson. (RX 1) Dr. Anderson never met or examined Petitioner. Dr. Anderson noted that Petitioner had a remote chance of requiring hardware removal. At the time of his review on August 5, 2016, he found

Petitioner to be at MMI for both the wrist fracture and for carpal tunnel syndrome. *Id.* Considering the fracture and the resulting impairment, Dr. Anderson found Petitioner to have a 5% upper extremity permanent impairment. *Id.* Alternatively, considering the fracture and the carpal tunnel syndrome, and the resulting impairment, Dr. Anderson found Petitioner to have a 4% upper extremity impairment. *Id.* Dr. Anderson explained that when the same region, in this case the upper extremity, has two diagnoses, the most-impairing diagnosis, and the highest impairment rating, are used to adequately reflect the loss. *Id.* Dr. Anderson concluded Petitioner has suffered a 5% upper extremity, or 3% whole person, impairment. *Id.*

At the time of hearing Petitioner testified that his right wrist extension is not as full as his uninjured left hand. He also testified that he cannot make a tight fist with his dominant right hand. Weather changes cause pain in the wrist in the area of the plate. Petitioner testified that he fractured his right wrist as a child with an uneventful recovery. He denied any subsequent injuries.

CONCLUSIONS

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Anderson concluded Petitioner has suffered a 5% upper extremity, or 3% whole person, impairment. However, Dr. Anderson explained that with regard to the fractures, the resulting impairment was 5% of the upper extremity and with regard to the fracture and the carpal tunnel syndrome, the resulting impairment was 4% of the upper extremity, but when the same region has two diagnoses only the most-impairing diagnosis is used to calculate the entire impairment rating. The Arbitrator notes that the impairment rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator further notes the impairment rating under the AMA guides assesses impairment of the upper extremity, which by definition encompasses the whole arm, including the hand and fingers whereas the Act distinguishes between the arm and hand. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner is a correctional officer who supervises a prison kitchen, working side by side with prisoners. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was only 52 years old at the time of his dominant hand wrist fracture, so he has 15 more years to work with his injury. The Arbitrator therefore gives *some* weight to this factor.

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

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. The treatment records show that Petitioner had a lengthy recovery, with a second surgery. At the time of his discharge he still had a mild impairment in work function, such as opening containers and jars, and mild numbness in his right hand, and had decreased strength. The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 35% loss of use of the right hand pursuant to §8(e) of the Act.

The Arbitrator notes that Section 8(e)9 of the Act provides:

> Hand-
>
> 190 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.
>
> 205 weeks if the accidental injury occurs on or after February 1, 2006.
>
> 190 weeks if the accidental injury occurs on or after June 28, 2011 (the effective date of Public Act 97-18) and if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma, in which case the permanent partial disability shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand.(emphasis added)

The accidental injury in this case does, in part, involve carpal tunnel syndrome, but it is not due to repetitive or cumulative trauma. Therefore permanent disability is based upon 205 weeks.

Respondent shall pay Petitioner the sum of $755.22/week for a further period of 71.75 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 35% loss of use of the right hand.

15WC15563
15WC15564

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

Debra Manos,

Petitioner,

vs.

NO: 15 WC 15563
15 WC 15564

Ford Motor Company,

Respondent.

18IWCC0325

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, permanent partial disability, 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. 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 5, 2017 is hereby affirmed and adopted.

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

18IWCC0325

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 $9,300.00. 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: MAY 24 2018
o041918
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

MANOS, DEBRA
Employee/Petitioner

Case# **15WC015563**

15WC015564

FORD MOTOR COMPANY
Employer/Respondent

18IWCC0325

On 9/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

2194 STROM & ASSOCIATES
NEAL B STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

0560 WIEDNER & McAULIFFE LTD
DANIEL A BRAINARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

Debra Manos
Employee/Petitioner

v.

Ford Motor Company
Employer/Respondent

Case # 15 WC 15563

Consolidated cases: 15 WC 15564

18IWCC0325

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0325

FINDINGS

On the date of accident, **September 24, 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 **$27,444.19**; the average weekly wage was **$623.73**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **3** dependent children.

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

The parties agree Respondent paid $15,811.93 in temporary total disability benefits before the disputed period of January 18, 2017 through June 21, 2017. They also agree Respondent paid $26,772.50 in non-occupational indemnity disability benefits, with Petitioner disputing that Respondent is entitled to Section 8(j) credit in this amount. Arb Exh 1.

ORDER

SEE THE DECISION IN 15 WC 15564 FOR THE ARBITRATOR'S AWARD OF BENEFITS.

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

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

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

Molly C Mason

Signature of Arbitrator

8/11/17
Date

ICArbDec19(b)

SEP - 5 2017

18IWCC0325

Summary of Disputed Issues in Both Cases

Petitioner, an assembly line worker, claims bilateral hand and arm conditions of ill-being. The Application in 15 WC 15563 alleges left hand and arm injuries of September 24, 2012 while the Application in 15 WC 15564 alleges right hand and arm injuries of March 18, 2013. The disputed issues include accident, causal connection, medical expenses, temporary total disability from January 18, 2017 through the hearing of June 21, 2017, penalties/fees, whether Petitioner is entitled to prospective care in the form of a right ulnar nerve transposition surgery recommended by Dr. Fernandez and whether Respondent is entitled to Section 8(j) credit. Arb Exh 1.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner testified she began working as an assembler for Respondent on November 3, 2010, after passing a required pre-employment physical examination. [Records in PX 9 reflect Petitioner underwent this examination on October 25, 2010 and completed a form that day indicating she was not experiencing pain in her hands, arms or shoulders. The examining physician, Dr. Akbar, found her capable of performing essential job functions.] She used the last name "Drosos" when she was hired but later got divorced and began using her maiden name, "Manos."

On direct examination, Petitioner denied undergoing any treatment for her arms prior to September 24, 2012. Records in PX 1 reflect Petitioner saw Dr. Legaspi on April 27, 2012 and complained that the knuckles in her fingers were "growing." The doctor ordered laboratory studies, including ESR blood work (to check for rheumatoid arthritis) and bilateral hand X-rays, citing a diagnosis of "polyarthritis." The ESR results were within a normal range. The X-rays showed no abnormalities. Other records in PX 1 reflect Petitioner called her doctor's office on September 20, 2012 indicating she "hurt herself @ work" and asking that a prescription for Vicodin be called in. Petitioner also indicated she was not able to come in to see the doctor because she had not yet reported the injury to her employer. [Also see RX 2.]

Petitioner testified each shift lasted 11.5 hours. She was afforded a ½-hour lunch break during that time. Overtime was required. She worked between 55 and 60 hours per week.

Petitioner testified she worked in the chassis department. This department had two moving lines. A car came down the line every 58 seconds. Her first job involved working on the line, installing cruise control boxes and heat shields. As each car came down the line, she had 58 seconds to perform the following tasks: 1) "hand start" three bolts, i.e., tightening three bolts using her fingers; 2) using an air gun to shoot the bolts; 3) using a torque wrench to measure the tightness of each bolt; 4) using her thumbs to push pins. Later, she began performing a different assembler job on the same line. As each car came down the line, she

had to push a rear seat assembly into place. That job did not involve bolts but she did have to use her hands to snap belt buckles into position.

Petitioner testified she began working at 6 AM on September 24, 2012. On that day, she repeatedly used an "eagle" gun to tighten screws and moved plastic bins from the top of a rack to the bottom as the parts within each bin were depleted. Each bin weighed 10 pounds when empty. Petitioner testified she had to constantly extend her arms to reach and reposition the bins. She experienced an immediate onset of an "icepick" sensation in her elbow as she transferred a bin. She reported this to her supervisor [notice is not in dispute] and then went to Respondent's in-house medical department at his direction. She received ice at the medical department and was sent back to work.

Documents in PX 9 (records from Respondent produced pursuant to subpoena) include an injury report that Petitioner completed on September 24, 2012. In this report, Petitioner indicated she "pulled something in left elbow" at 9 AM that day while "moving stock bins."

Petitioner testified she saw her personal care physician for her elbow injury on September 26, 2012. Records in PX 1 reflect Petitioner saw Dr. Legaspi on that date and complained of severe pain in her left elbow radiating down her arm secondary to moving her arm at work while "pulling stock bins." Dr. Legaspi examined Petitioner, diagnosed left lateral epicondylitis and injected Petitioner's left elbow with Kenalog. He directed Petitioner to return to him in two weeks if she did not experience improvement. PX 1.

Records in PX 9 reflect Petitioner requested an intermittent work schedule on September 12 and October 15, 2012, pursuant to the Family and Medical Leave Act [FMLA], to care for her father. PX 9.

Petitioner returned to Dr. Legaspi on November 7, 2012, with the doctor noting the following complaints: "work comp – 9/24/12 – pt c/o left elbow pain still." On re-examination, the doctor noted tenderness in the left lateral epicondyle. He again diagnosed epicondylitis and administered another injection. PX 1.

Petitioner saw Dr. Legaspi again on November 29, 2012 and complained of hives secondary to taking Benadryl and steroids. On re-examination, the doctor again noted tenderness in the left lateral epicondyle. He prescribed Vicodin, with no refill, for this condition. PX 1.

Petitioner testified she also engaged in physical therapy, per her doctor, during this period while continuing to work. [No therapy records from 2012 are in evidence.] Petitioner testified she was switched to "light duty" but she did not feel like she was on light duty because many of her assigned tasks remained the same. She continued to work as an assembler on a line, "hand starting" bolts. She became a "floater," meaning she filled in for other workers as needed. Her work schedule did not change.

Petitioner testified she was re-injured on March 18, 2013, while performing an "inspector type job" on one of the lines. This job consisted of using a torque wrench to check the tightness of bolts and filling bins with stock. She felt as if her arms were on fire. She also experienced an "icepick" sensation, very sharp pain and warmth in her right elbow. The "icepick" sensation extended to her hand. She felt numbness and tingling in her thumb and fingers. She reported her injury to Frank, her supervisor [notice is not in dispute] and, at his direction, went to Respondent's in-house medical department. A Respondent "injury/accident investigation" form in PX 2 reflects Petitioner reported right elbow pain and finger numbness to a supervisor named "Frank G." at 1 PM on March 18, 2013. This form also reflects Petitioner attributed her symptoms to using a "torque oxygen sensor on side of engines, moving stock bins, squeezing, pulling." PX 9.

Records in PX 9 reflect Petitioner underwent surgery to remove a plantar wart on April 17, 2013, developed an infection thereafter and underwent additional surgery by Dr. Schwartzman, a podiatrist, on June 28, 2013. Petitioner was kept off work from April 17, 2013 through late July 2013 due to her inability to stand. A Respondent "short term medical justification" form reflects Petitioner returned to work on July 29, 2013.

On August 22, 2013, Petitioner completed an accident report form reflecting she was experiencing tingling and numbness in her fingers secondary to "hand starting screws on different jobs every day." PX 9.

Petitioner testified that, at Respondent's direction, she underwent an upper extremity EMG/NCV on September 30, 2013. Dr. Holmes, a neurologist, performed this study. He recorded the following history:

> "The patient is a 50-year-old right-handed 5 foot 3 inch female seen for complaints of numbness, pain and tingling in both arms. She [has] been working on the assembly line [at] Ford Motor Company for about 3 years and has noticed some swelling in the thickness of the fingers over time and more recently is having complaints of numbness, pain and tingling in all of the fingers in both hands, particularly the first 3 volar digits in both hands, that gets worse with certain activity and can wake her up from sleep. She also has increased symptoms when she has her elbow bent and resting on the elbow or holding a telephone. She denies any history of diabetes. She has occasional neck discomfort as well."

On examination, Dr. Holmes noted positive Tinel's on the right only over the carpal tunnel region, positive Tinel's bilaterally over the cubital tunnel region bilaterally, positive Phalen's bilaterally, 5/5 strength and normal sensation to pinprick except for slight subjective relative decreased pinprick sensation in the right lateral volar proximal forearm.

Dr. Holmes interpreted the EMG/NCV as showing a mild right median neuropathy, consistent with mild right carpal tunnel syndrome, and a mild right ulnar neuropathy with

conduction slowing across the elbow. He found no evidence of any active left median or ulnar neuropathy and no evidence of any active cervical radiculopathy involving either upper extremity. PX 9.

On November 19, 2013, Dr. Patel of the Munster Orthopedic Clinic evaluated Petitioner due to bilateral hand numbness and elbow pain. Dr. Patel released Petitioner to light duty, with use of braces and no overuse of the hands or arms. PX 9.

On December 3, 2013, an occupational therapist at PTSIR conducted an evaluation of Petitioner per Dr. Lewis, a physician affiliated with Respondent. The therapist's history reflects that Petitioner described working as a "general" on Respondent's chassis line during the preceding three years, performing "all jobs" involved in the motor line. The history also reflects that Petitioner complained of bilateral hand and elbow symptoms, left worse than right, of one year's duration, and reported having undergone an EMG and multiple elbow injections. PX 9.

Petitioner underwent occupational therapy at PTSIR between December 5 and 19, 2013 and in January 2014. PX 9.

Records in PX 9 reflect Petitioner requested an intermittent work schedule pursuant to the Family and Medical Leave Act [FMLA] as of February 26, 2014, to care for her father.

Petitioner testified she decided to consult Dr. Fernandez, a hand surgeon, after doing some research online. She first saw the doctor on February 27, 2014. Documents in PX 9 reflect that Michele Gregory, a Respondent "workers' compensation rep," provided written authorization for this visit on February 6, 2014, so that Dr. Fernandez could provide a second opinion.

Dr. Fernandez's initial treatment note of February 27, 2014 reflects that Petitioner was referred to him for evaluation of bilateral hand and arm complaints. He indicated that Petitioner denied any specific event or trauma and attributed her symptoms to work activities such as lifting heavy stock and operating hoses and compressors. He also indicated that Petitioner's symptoms "began in August 2013."

Dr. Fernandez indicated that Petitioner reported experiencing only transient relief from four left elbow injections and two right elbow injections.

Dr. Fernandez noted the results of the September 30, 2013 EMG/NCV.

On examination, Dr. Fernandez noted calluses on both hands, particularly at the base of the middle and ring fingers. He saw no evidence of chronic regional pain syndrome. On neurologic testing, he noted positive Tinel's, Phalen's and median nerve compression tests at the wrist and "similar irritability at the elbow, although not nearly as severe." He described his physical examination findings as similar, "although not as severe on the left side." He noted no atrophy or motor dysfunction. He noted no obvious deformity other than prominence at the

base of the thumb and in the small joints of the fingers. He noted "very discrete tenderness at the medial epicondyle greater than the lateral epicondyle, right greater than left" and "moderate pain at the base of the thumb and in the small joints of the digits consistent with Heberden's nodules and osteoarthritis."

Dr. Fernandez obtained X-rays of Petitioner's hands and wrists. He interpreted the films as showing "early degenerative findings of the basilar joint as well as the small joints of the digits." He described these findings as more severe on the right and "stage II in nature."

Dr. Fernandez diagnosed bilateral carpal and cubital tunnel syndrome, right greater than left, bilateral thumb basilar joint degeneration and bilateral elbow medial greater than lateral epicondylitis, right greater than left.

Dr. Fernandez indicated he discussed various treatment options with Petitioner, with Petitioner opting for carpal and cubital tunnel surgery. He recommended that the right side be addressed first and informed Petitioner he would seek authorization. He prescribed a Medrol Pak, Ultram and Voltaren. He released Petitioner to work subject to a "light use restriction regarding both upper extremities" and use of Neoprene sleeves. PX 2, 9.

A document in PX 2 reflects that Dr. Lewis of Respondent authorized the proposed surgery in writing and asked Dr. Fernandez to send his operative report to him.

On April 21, 2014, Dr. Fernandez performed a mini-open right carpal tunnel release and right ulnar nerve release at Gold Coast Surgicenter. In his operative report, he documented moderate compressive changes of the median nerve at the wrist and moderate to more moderately severe findings of the ulnar nerve of the elbow, "particularly underneath Osborne's ligament just distal to the tip of the epicondyle." He directed Petitioner to stay off work and start therapy in one week. Records in PX 9 reflect Petitioner attended therapy at PSTSIR facilities in Blue Island and Lansing thereafter. On April 29, 2014, Petitioner's therapist noted that Petitioner "demonstrated continuous re-aggravation of the right upper extremity, particularly with work and home related activities."

Petitioner saw Dr. Fernandez on May 6, 2014 and reported some improvement but not full resolution of her finger numbness following the right-sided surgery. Petitioner also complained of numbness and tingling in her left hand. Dr. Fernandez recommended left-sided surgeries. He released Petitioner to light duty with no use of the right arm and less than 10 pounds of force involving the left arm. PX 2.

Documents in PX 9 reflect that Mary Brown, R.N., a nurse at Respondent, released Petitioner to work as of May 7, 2014, with no use of the right arm.

On June 3, 2014, Petitioner returned to Dr. Fernandez. The doctor indicated that Petitioner's finger symptoms had resolved since the surgery but that she was still experiencing pain and sensitivity along the incision as well as difficulty using her right hand to turn a key, cut

vegetables or open a bottle. He also indicated that Petitioner was performing light duty and wanted to hold off on any left-sided surgery until her right-sided symptoms improved. On re-examination, the doctor noted discomfort along the incision site and a full range of motion in the hand, wrist and elbow. He recommended that Petitioner continue therapy for her right hand and arm and continue using a long-arm splint on her left arm at night "to keep her comfortable while she waits for her right side to improve." He released Petitioner to one-handed work with no use of the right arm and lifting up to 10 pounds with the left arm. PX 2.

Petitioner saw Dr. Fernandez again on July 8, 2014. The doctor indicated Petitioner complained of right-sided palmar pain and sensitivity that increased "after doing significant repetitive motion, especially while using an air gun at work where she has to kind of rotate and extend her wrist." He also indicated that Petitioner was still experiencing left-sided symptoms. On re-examination, he noted positive Tinel's and Phalen's at the level of the left wrist and some hypersensitivity with Tinel's at the left elbow. He again recommended left-sided surgery. He also recommended that Petitioner continue therapy for her right-sided symptoms. He continued his previous work restrictions. PX 2, 9.

Dr. Fernandez took Petitioner off work as of September 11, 2014.

On September 15, 2014, Dr. Fernandez performed a left carpal tunnel release and left ulnar nerve/cubital tunnel release, again at Gold Coast Surgicenter. In his operative report, he documented "moderate compression findings of the median nerve at the wrist and the ulnar nerve at the elbow, with local perineural fibrosis and thickening consistent with moderate compression." PX 9.

On September 30, 2014, Petitioner reported some left-sided improvement to Dr. Fernandez but indicated her right-sided numbness and tingling had returned secondary to overuse. On examination, the doctor noted "continued complaints on the right ulnar nerve distribution." He diagnosed bilateral thumb basilar joint degeneration and bilateral elbow medial greater than lateral epicondylitis, worse on the right. He recommended bilateral therapy and released Petitioner to light work with less than 10 pounds of force involving the right arm. Records in PX 9 reflect Petitioner attended therapy on various dates between September 23, 2014 and November 6, 2014.

A form in PX 9 reflects Petitioner returned to restricted duty at Respondent as of October 23, 2014.

At the next visit, on November 11, 2014, Petitioner complained to Dr. Fernandez of aching in her elbows and some residual numbness and tingling in the medial nerve distribution. She also reported "increased discomfort with work activities, particularly while performing pulling and gripping." The doctor noted swelling in both elbows. He recommended work conditioning and released Petitioner to light duty with less than 5 pounds of force utilizing the right arm.

Petitioner began a course of work conditioning thereafter.

On January 13, 2015, Petitioner returned to Dr. Fernandez and indicated she had aggravated her right elbow during work conditioning. She reported taking Vicodin for pain relief. The doctor prescribed a Medrol DosePak and directed Petitioner to finish her work conditioning program. He continued to restrict Petitioner to light duty.

On February 10, 2015, Petitioner again complained to Dr. Fernandez of elbow pain, worse on the right. The doctor discussed the possibility of additional right elbow surgery. He noted that Petitioner wanted time to consider this. He again imposed light duty, with no use of the right arm. PX 9.

On February 26, 2015, Sadie Miller, a nurse affiliated with Respondent, found Petitioner capable of resuming light duty as of February 26, 2015.

On March 17, 2015, Dr. Fernandez continued the previous restrictions. PX 9.

Dr. Fernandez operated again on April 20, 2015, performing a right elbow medial epicondylectomy.

Petitioner testified that Respondent authorized the surgeries Dr. Fernandez performed on April 21, 2014, September 15, 2014 and April 20, 2015.

Records in PX 9 reflect Petitioner went off work on April 17, 2015 due to a work-related disorder which is described as "repetitive use on the job." Mary Brown, a nurse associated with Respondent, released Petitioner to restricted duty as of May 7, 2015. PX 9.

Other records in PX 9 reflect Petitioner was off work between May 14, 2015 and July 21, 2015 due to a "stress reaction" for which she underwent treatment with Dr. Robbins of the Center for Mental Wellness.

On July 7, 2015, Petitioner complained to Dr. Fernandez of persistent elbow pain, worse on the right. The doctor prescribed a Medrol Dosepak and work conditioning. He released Petitioner to light duty with no use of the right arm and no repetition or lifting over 5 pounds with the left arm. PX 2.

Records in PX 9 reflect Petitioner began a course of work conditioning on July 27, 2015.

Petitioner returned to Dr. Fernandez on September 1, 2015 and reported no improvement of her elbow pain. She also complained of pain along the CMC joint. Dr. Fernandez placed Petitioner at maximum medical improvement and released her from care, subject to light duty restrictions of less than 20 pounds of force utilizing the upper extremities. PX 2.

Petitioner testified she resumed working for Respondent after September 1, 2015, subject to Dr. Fernandez's restrictions.

On October 8, 2015, Dr. Legaspi referred Petitioner to Dr. Morker for pain management. PX 5.

Petitioner first saw Dr. Morker on November 13, 2015. In his note of that date, the doctor recorded a history of the work accidents and subsequent treatment. He indicated that Petitioner experienced relief of her neuropathic pain following surgery but was still experiencing pain over the medial aspects of her elbows. He noted that Petitioner was taking Hydrocodone and Tramadol for this pain. After examining Petitioner, he continued these medications and added Lyrica and Cymbalta, along with home exercises. PX 5.

Petitioner saw Dr. Morker again on November 30, 2015. The doctor noted that Petitioner had started taking Lyrica and Cymbalta but had discontinued these medications due to concern about side effects. He also noted that Petitioner was still experiencing a "constant stabbing sensation" in both elbows which worsened with pronation and supination. He continued the Hydrocodone, discontinued the Tramadol and directed Petitioner to restart the Lyrica and Cymbalta. PX 5.

At the next visit, on January 4, 2016, Dr. Morker noted that Petitioner was doing well with her current medications but was still experiencing bilateral elbow pain. He increased the Lyrica dosage and continued the other medications. PX 5.

On March 29, 2016, Dr. Morker noted that Petitioner was experiencing increased symptoms, having "weaned herself off of her Lyrica and Cymbalta after her previous appointment due to side effects." He increased Petitioner's Hydrocodone dosage. PX 5.

Documents in PX 9 reflect Petitioner went off work as of April 19, 2016 due to a "repetitive motion" injury and restrictions Respondent did not accommodate. These documents include a "medical restriction placement process" note dated April 19, 2016 signed by a team manager, Walter Simkus, and a labor relations representative, whose signature is not legible.

Petitioner next saw Dr. Morker on May 10, 2016. The doctor noted that Petitioner had been "placed on permanent disability since her previous appointment." He continued the Hydrocodone, performed a drug screening and recommended a psychological evaluation. PX 5.

Thomas Grzesik, a certified vocational rehabilitation counselor, met with Petitioner on June 14, 2016 to assess her employability and vocational rehabilitation potential. On June 23, 2016, Grzesik issued a lengthy report concerning his assessment. In this report, Grzesik indicated he reviewed records from Respondent along with numerous treatment records. He indicated that Petitioner reported graduating from high school and briefly attending South

Suburban College. He also indicated that Petitioner reported completing training for a real estate license twenty years earlier, while working at a real estate office, but was not licensed.

Grzesik indicated that Petitioner reported constant bilateral elbow pain, for which she was taking Vicodin, as well as periods of depression. He also indicated that Petitioner had last performed light duty for Respondent on April 18, 2016, at which point she was told she could no longer be accommodated. He stated that Petitioner had recently tried to make an appointment to return to Dr. Fernandez but had been told by the doctor's staff she would need advance authorization from workers' compensation to be seen.

Grzesik noted that Petitioner reported being able to perform most of her indoor household chores "but at a slow pace and with rest breaks." He also noted she obtained assistance from relatives and friends when it came to outdoor chores. He indicated that Petitioner reported occasionally cutting and grinding glass, while working on her stained glass collection, and no longer participated in her prior hobbies of snowmobiling, jet skiing, bowling and gardening.

Based on the restrictions imposed by Dr. Fernandez, Grzesik found Petitioner no longer able to perform her prior motor vehicle assembler job. He further found that Petitioner met the criteria for participation in vocational rehabilitation. He opined that Petitioner "is employable in entry level clerical, sales and service occupations" with the entry level hourly wages for those occupations ranging from $8.44 to $11.67. He recommended she undergo comprehensive vocational testing. He indicated that Petitioner remained interested in real estate sales but would need to undergo six weeks to three months of training in order to be able to take and pass the real estate license examination. He recommended that Petitioner obtain assistance with job placement activity and/or formalizing career goals. PX 6.

On July 18, 2016, Dr. Morker continued the Hydrocodone and started Petitioner on a LidoPro topical ointment. PX 5.

On September 12, 2016, Dr. Morker noted that Petitioner was frustrated "by her lack of ability to be functional due to her pain." He continued the Hydrocodone and topical ointment, started Petitioner on Duexis and Savella. PX 5.

At Respondent's request, Dr. Neal examined Petitioner on September 14, 2016, pursuant to Section 12 of the Act. RX 1, p. 7. [See below for a summary of the doctor's deposition testimony concerning this examination.]

Petitioner testified that Dr. Neal found her capable of full duty. After Dr. Neal examined her, she attempted to resume full duty for Respondent. Her job duties at this point consistent of putting wire harnesses on top of engines. This involved guiding, using push pins, and hand starting screws. Petitioner testified the harnesses were stiff and difficult to guide. Her arms felt like they were "on fire" while she performed the harness-related work. She reported her symptoms to her supervisor, Victor, who sent her to Respondent's in-house medical

department. She was given ice and was told to resume working. She attempted full duty for another half hour and then asked to return to the medical department. At the medical department, she was given Motrin and more ice. Her supervisor asked if she wanted to leave work and she left. She reported to work the following day. A carriage had broken and cars had to be transferred from one line to another. She assisted with the transfer process for about one week and was then sent home.

On November 2, 2016, Dr. Neal issued a supplemental report after Respondent's counsel asked him to address whether Petitioner's allegations of accidents occurring on September 24, 2012 and March 18, 2013 would prompt him to change any of the opinions he previously rendered. He responded "no." He opined that none of Petitioner's left-sided complaints stemmed from a September 24, 2012 accident "or work activities in general" and that none of her right-sided complaints stemmed from a March 18, 2013 accident "or work activities in general." Neal Dep Exh 3.

Petitioner returned to Dr. Fernandez on December 13, 2016 and again complained of 5/10 bilateral elbow pain, worse on the right. She indicated she was seeing Dr. Morker at a pain clinic and taking Hydrocodone for discomfort.

Dr. Fernandez noted that Petitioner described her pain as starting on November 14, 2016 "when she was [performing] a loom job at work." On examination, her noted some swelling involving the surgical site, primarily along the right medial elbow, and discomfort along the right medial and lateral elbow. He administered a right elbow lateral epicondylar injection and recommended additional surgery. He also directed Petitioner to wear short arm splints at night. He released Petitioner to one-handed work with no use of the right arm.

On January 6, 2017, Dr. Fernandez issued a lengthy report in which he responded to various questions posed by Petitioner's counsel. In this report, Dr. Fernandez described Petitioner's conditions as "multi-factorial" but opined that the injuries and work activities "had some contributory effect." He described Dr. Neal's causation-related opinion as "flawed," indicating it did not matter whether Petitioner performed more than one task if the tasks she performed involved gripping, grasping, pushing, pulling and tool usage. He imposed permanent restrictions consisting of no lifting over 10 to 20 pounds and avoidance of repetition. PX 3.

On January 26, 2017, Dr. Fernandez again recommended right ulnar nerve transposition surgery. He imposed permanent restrictions of 10 pounds of force frequently and 20 pounds of force occasionally with repetition limited to no more than 15 minutes every hour. PX 2.

Dr. Fernandez testified by way of evidence deposition on January 31, 2017. PX 8.

Dr. Fernandez testified he is board certified in orthopedic surgery with added qualification in hand surgery. He subspecializes in upper extremity surgery involving the hands, wrists and elbows. He has a secondary focus on microsurgery. On average, he sees 150

patients per week. PX 8, pp. 5-6. About one third of his patients have occupational injuries. PX 8, p. 6.

Dr. Fernandez testified he has some independent recollection of Petitioner but would find it helpful to see his chart notes. PX 8, pp. 6-7. When he first saw Petitioner, on February 27, 2014, she had already undergone some treatment, including elbow injections, with Dr. Sardesai. She had also undergone an EMG, which was "positive on the right side."

Dr. Fernandez testified his initial examination revealed numbness, tingling and irritability of the median nerve at the wrist and ulnar nerve at the elbow, right worse than left, as well as tenderness at the median greater than lateral epicondyle, again right worse than left. Petitioner also exhibited some swelling at the base of her thumb, consistent with arthritis that was confirmed via X-rays obtained that day. PX 8, pp. 8-9. Petitioner's subjective complaints correlated with her positive EMG and X-rays. PX 8, pp. 9-10.

Dr. Fernandez testified he saw no evidence of malingering. PX 8, p. 10. He indicated that Petitioner attributed her symptoms to her assembler job, which she had performed since 2010. PX 8, p. 10.

Dr. Fernandez testified he initially diagnosed bilateral carpal and cubital tunnel, bilateral epicondylitis, right greater than left, and some bilateral thumb arthritis. He recommended bilateral carpal and cubital tunnel releases, since Petitioner had already undergone a fair amount of non-surgical care. PX 8, p. 11.

Dr. Fernandez opined that an individual can develop work-related carpal tunnel syndrome within about six weeks, depending on the intensity of the exposure to repetition and force. It takes about six weeks for physiologic changes to occur within the carpal tunnel. PX 8, pp. 11-12. He performed bilateral carpal tunnel releases on Petitioner based on his examination findings, the EMG results and the fact Petitioner had exhausted conservative measures, including injections. PX 8, pp. 11-12. Petitioner reported improvement of her numbness and tingling after the right-sided surgery, on April 21, 2014, and the left-sided surgery, on September 15, 2014. On September 30, 2014, however, Petitioner told him her right-sided symptoms were "starting to return," due to increased usage of her right hand and arm. PX 8, pp. 13-14. He allowed Petitioner to perform light duty during this period because it was safe for her to use her hands or arms in a very light or sedentary way. In November 2014, however, Petitioner reported some elbow swelling and pain, which she attributed to pulling and gripping at work. PX 8, pp. 14-15. As of early 2015, he recommended a right medial epicondylectomy debridement. He continued to allow Petitioner to perform light duty, "even if it was uncomfortable," until March 2015, at which point he restricted her to left hand usage only. On April 20, 2015, he performed a right medial epicondylectomy and a release and debridement of the common flexor origin. In layman's terms, he removed a small amount of bone where the tendon is attached to the bone, removed part of the tendon and then lengthened it "so that it's not so tight when it's pulled on." He also released the ulnar nerve but left the nerve in the bed it is in. PX 8, pp. 19-20. Postoperatively, Petitioner remained

symptomatic and indicated her right elbow felt the same as it had felt before the surgery. He prescribed work conditioning and a Medrol Dosepak. Overall, he felt Petitioner improved but her elbow complaints "were the least improved." PX 8, p. 22. When he saw Petitioner in September 2015, she told him she was taking Norco once daily, along with Tramadol, and did not feel she could resume full duty due to her complaints. At that point, he felt Petitioner had "plateaued and failed the work conditioning program" and had reached maximum medical improvement. He imposed light duty with respect to poundage and repetition. He also recommended home therapy. He released Petitioner from care on a PRN basis. PX 8, pp. 23-25. Petitioner returned to him in December 2015, complaining of lateral pain in both elbows, worse on the right. Petitioner told him she performed a "loom job" at work in November and felt this job caused her right-sided symptoms to flare. PX 8, p. 25. On examination, he noted objective swelling at the surgical sites, primarily along the right medial and lateral elbow. He did not view this as typical post-operative swelling. PX 8, pp. 25-26. He believed it could be due to "continued active disease." PX 8, p. 26. He also noted subluxation of the ulnar nerve, meaning the nerve was "popping out of its groove." PX 8, p. 26. He discussed the prospect of additional right elbow surgery with Petitioner. Petitioner returned to him on January 26, 2017, at which time he again recommended this surgery, based on Petitioner's persistent symptoms. PX 8, p. 27.

Dr. Fernandez testified he prepared a narrative report at the request of Petitioner's counsel. PX 8, p. 28. In this report, he opined that Petitioner's various conditions, including bilateral carpal and cubital tunnel syndrome and bilateral elbow epicondylitis, were "caused or aggravated by her work activities." During the preceding two years, Petitioner had experienced "frequent exposure to pushing, pulling, grasping" and tool usage. Petitioner's symptoms started in 2012 and it seemed she had a further aggravation at work in 2013. PX 8, p. 29.

Dr. Fernandez testified that not all individuals who are exposed to repetitive work develop the conditions that Petitioner has. In his opinion, there is "clearly something that predisposes certain people to developing these conditions." PX 8, p. 30. Female gender, age and external factors, including increased body mass index and smoking, can also play a role. While Petitioner is a middle-aged female who is a "little bit overweight" and smokes, he believes Petitioner's job duties also played a role, because her problems were bilateral and multi-level in nature. This is not common in idiopathic cases. PX 8, p. 32. Additionally, there is no evidence Petitioner had hand or arm problems before she began working at Ford. PX 8, p. 32.

Dr. Fernandez testified he respects Dr. Neal and believes his report was very well written and thorough. In his view, Dr. Neal disagrees with his causation-related opinions but agrees with his treatment recommendations. The basis of Dr. Neal's causation opinion was the fact that Petitioner's job activities were varied. PX 8, p. 33. He respectfully disagrees with Dr. Neal on that. PX 8, p. 34. He also disagrees with Dr. Neal's opinion that Petitioner can perform full duty. PX 8, p. 34. He does not know where Dr. Neal came up with an accident date of August 20, 2013. This is the date of an incident report Petitioner completed but Petitioner consistently attributed her condition to cumulative exposure at work. PX 8, p. 36.

Dr. Fernandez conceded he did not recommend additional care in September 2015. It was later, after an additional period of work, that Petitioner's condition worsened, prompting him to recommend more right elbow surgery. PX 8, p. 38. Petitioner's condition changed objectively between September 2015 and December 2016, "most notably in ulnar nerve instability." Assuming Petitioner's condition has not changed, he would still recommend the surgery. PX 8, pp. 38-39.

Under cross-examination, Dr. Fernandez conceded Petitioner's September 2013 EMG showed no evidence of left-sided carpal or cubital tunnel syndrome. PX 8, p. 40. In January 2015, Petitioner reported that her left arm was better. PX 8, p. 42. As of September 1, 2015, he imposed permanent restrictions and believed Petitioner was at maximum medical improvement. PX 8, p. 43. He did not base the need for restrictions solely on subjective complaints. He hoped that, ultimately, Petitioner would be capable of performing more physical work. PX 8, p. 45. He does not know whether Petitioner worked during the entire period between September 2015 and December 2016. It is possible Petitioner worked only two months during this period. PX 8, p. 45.

Dr. Fernandez agreed that Petitioner's job activities appear to be varied but they all required repetitive, frequent usage of both hands, sometimes with tools. Petitioner had exposure to gripping, grasping, pushing and pulling, using both hands. Some of the tasks seemed relatively light but others were "more forceful in nature." PX 8, p. 47. He does not know exactly what percentage of the tasks involved bilateral hand usage or tool usage. PX 8, p. 47. He did not see any job video and cannot recall whether he saw a job description. PX 8, p. 48. He relied on Petitioner's description of her job. Over the years, some patients have provided him with misleading information. He asked Petitioner about her non-work activities but she did not describe any hobbies that would have been contributory. PX 8, p. 48. Even if Petitioner, hypothetically, pursued a hobby that involved repetitive and forceful hand and arm usage eight hours a day, after her workday, that would not change the causative or aggravating activities she performs at work. PX 8, pp. 48-49. Normal household chores, such as emptying the garbage and cleaning, would not contribute to the development of the conditions. PX 8, p. 50. Atypical cell phone usage, i.e., four hours per day, with the elbow bent, could aggravate cubital tunnel but it would have no effect as to carpal tunnel or epicondylitis. PX 8, pp. 50-51.

On redirect, Dr. Fernandez testified that the term "maximum medical improvement" does not mean full resolution of a health condition. A person who plateaus at one point might later require care. PX 8, pp. 51-52. When Petitioner returned to him in December 2016, her condition had materially changed, prompting him to recommend more care. PX 8, p. 53.

Dr. Fernandez testified he has treated people with work-related injuries since he began practicing medicine. Such injuries are a "big part of every orthopedic surgeon's practice." PX 8, p. 54. The fact that he lacks a formal job description does not impact his opinions, unless Petitioner grossly misrepresented her duties. He disagrees with Dr. Neal because, regardless of

whether Petitioner was assigned to task A, B or C, each of those tasks could be contributory. PX 8, p. 56.

Dr. Neal testified by way of evidence deposition on February 24, 2017. During the deposition, Respondent's counsel identified four exhibits (the doctor's CV, initial examination report and supplemental reports) as exhibits but offered only Deposition Exhibits 1 and 3, the CV and supplemental report of November 2, 2016, into evidence. Petitioner's counsel did not object to these two exhibits. RX 1, p. 42. The Arbitrator does not view the remaining exhibits (2 and 4) as part of the record in this case.

Dr. Neal testified he is board certified in orthopedic surgery. He underwent fellowship training in hand and upper extremity surgery in 1995 and 1996 and went into private practice in August 1996. RX 1, pp. 5-6. Neal Dep Exh 1. He devotes 40 to 50% of his general orthopedic practice to upper extremity problems. RX 1, p. 6. He operated on the hands, wrists, elbows and shoulders. He averages about 100 surgeries per year. RX 1, pp. 6-7.

Dr. Neal testified he personally obtained a history from Petitioner when he examined her on September 14, 2016. RX 1, pp. 7-8. At that examination, Petitioner indicated she had last performed full duty in 2012 and had last worked in any capacity in May 2016. RX 1, pp. 10-12. She indicated that she typically "filled in" at work, as needed, and did not know what job she would be performing from one day to another. RX 1, p. 11. She complained of bilateral arm pain and kept her right arm tight to her body. RX 1, p. 12. After he asked her to demonstrate the locations of her right-sided pain, she pointed to the posterior medial elbow, the back posterior arm, the finger PIP area and the thumb musculature area. RX 1, p. 13. She described her left-sided areas of pain as identical. She indicated her left-sided symptoms were less severe than her right-sided symptoms. RX 1, pp. 14-15. She provided a past medical history of depression, high cholesterol and anxiety. RX 1, p. 16. She reported taking Hydrocodone on a daily basis for two years. She also reported having taken Tramadol in the past, starting in 2012. RX 1, pp. 16-17.

Dr. Neal testified he reviewed a job description. On right upper extremity examination, he noted a report of "zinging" with Tinel's testing at the olecranon. He described this complaint as non-physiologic and non-organic. RX 1, p. 19. He also noted "some mild right-sided thenar weakness." RX 1, p. 19. He described Petitioner's right hand grip strength as good. On left upper extremity examination, he noted some mild thenar weakness, no evidence of epicondylopathy at the wrist, negative Tinel's at the elbow and good grip strength. RX 1, pp. 18-20. With respect to both upper extremities, he diagnosed pain and paresthesias of unknown etiology. RX 1, p. 21. It was "not surprising" that Petitioner exhibited no evidence of carpal tunnel syndrome, given that she had already undergone surgery. RX 1, p. 21.

Dr. Neal testified that Petitioner's history of depression and anxiety, along with her reported daily usage of narcotic pain medication, raised the possibility of narcotic dependence. RX 1, p. 21.

Dr. Neal found no causal relationship between Petitioner's work activities and her diagnoses. RX 1, p. 22. In his view, Petitioner's records did not reflect evidence of an abrupt injury on a specific date. Dr. Fernandez did not note a specific onset of symptoms. He indicated that Petitioner described her symptoms as starting in August 2013. RX 1, p. 25. In contrast, Petitioner told him (i.e., Dr. Neal) her symptoms started on specific dates in September 2012 and March 2013. RX 1, pp. 26-27.

Dr. Neal testified that Petitioner's job "changed daily." Petitioner "admitted to doing a lot of different jobs and filling in where needed." RX 1, p. 27.

Dr. Neal testified Petitioner is right-handed. Individuals typically use their dominant hands "a lot more" than their non-dominant hands. He finds it unusual that Petitioner developed an abrupt onset of symptoms in her non-dominant hand and arm on one day in September 2012. RX 1, pp. 31-32.

Dr. Neal testified he cannot conclude that Petitioner's multiple diagnoses are congenital in nature. Instead, he would characterize them as genetic. Petitioner's bilateral CMC arthritis has a "well-recognized genetic component." RX 1, p. 35. Carpal tunnel syndrome also has a "strong genetic element." RX 1, p. 35. The medical literature is "silent" with respect to the issue of whether cubital tunnel syndrome is genetic. RX 1, p. 35.

Dr. Neal testified he is unable to offer a single diagnosis for either extremity that would explain Petitioner's complaints. RX 1, p. 36. His opinion that Petitioner's complaints are of unknown origin is based on his examination findings and "related biopsychosocial issues." RX 1, p. 38.

Dr. Neal opined that, as of October 7, 2016, Petitioner required no additional care, at least insofar as her occupational activities and claimed injuries are concerned. RX 1, p. 39.

Dr. Neal testified he issued an addendum on November 2, 2016 to address the question of whether the left-sided symptoms could relate to a September 2012 time frame and the right-sided symptoms could relate to a March 2013 time frame. RX 1, pp. 41-42. In the addendum, he indicated his opinions remained unchanged. RX 1, p. 42. Neal Dep Exh 3.

Dr. Neal testified he issued another addendum in February 2017 after reviewing additional records from Dr. Fernandez. In this addendum, he indicated the new records did not prompt him to change any of his opinions. He referenced a medical article from September 2007, the AMA Guides and several other articles from medical journals relating to epicondylitis and thumb CMC arthritis. RX 1, pp. 44-46. In his opinion, carpal tunnel syndrome is most frequently idiopathic in nature. Additionally, idiopathic carpal tunnel syndrome is more common in women than men. RX 1, pp. 47-48. The syndrome also becomes more common as you age. RX 1, p. 49. Cubital tunnel syndrome is also most commonly idiopathic in nature. RX 1, p. 50. Epicondylitis is common as people pass into middle age. RX 1, p. 50. No study has

shown an "odds ratio" of 2.0 indicating a correlation between occupational activity and the development of epicondylitis. RX 1, p. 52.

Dr. Neal acknowledged he has a "high regard" for Dr. Fernandez. He further acknowledged that Dr. Fernandez has recommended additional surgery for Petitioner. Nevertheless, he continues to opine that Petitioner does not need more surgery because he believes that Petitioner's "underlying biopsychosocial issues are probably, most likely, the cause." RX 1, p. 54. He believes that Petitioner will not do well if she undergoes the surgery Dr. Fernandez has recommended. RX 1, p. 54.

Dr. Neal opined that Petitioner is capable of full duty with respect to her occupational injuries or issues. If Petitioner is unable to perform full duty due to symptoms, that is "related to non-occupational issues." RX 1, p. 55.

Under cross-examination, Dr. Neal testified he would have looked at Petitioner's medical records at the time she presented but then reviewed them more thoroughly afterward. RX 1, p. 57. He only examined Petitioner once, on September 14, 2016. RX 1, p. 57. He typically charges $1,000 for an examination. He charges an additional amount at a rate of $350 per hour when he is asked to review a lot of records. He charged a total of $2,750 for the September 14, 2016 examination. He charged $350 for his second report and has not yet billed Respondent for the third report of February 2017. RX 1, p. 59. He charges $750 per hour for deposition time. RX 1, p. 61. He has examined claimants but "not often." Only about 5% of his examinations are of claimants. RX 1, p. 63.

Dr. Neal testified that Petitioner attributed her conditions to "repetitive" work activities. RX 1, p. 63. He agrees Petitioner voiced symptoms at work on August 22, 2013 but he believes she had symptoms before that date. RX 1, p. 68. He was not provided with any records from Petitioner's primary care physician. RX 1, p. 72. To his knowledge, Dr. Fernandez also did not review such records. RX 1, p. 75. Petitioner told him she saw her primary care physician for work-related complaints. RX 1, p. 76. He has seen no records concerning any treatment rendered between September 24, 2012 and August 22, 2013. RX 1, p. 79.

Dr. Neal acknowledged he does not know all the jobs that Petitioner performed during her three years on the assembly line. RX 1, p. 87. He does not find it significant that Petitioner reported decreased symptoms during times she was not working. RX 1, p. 88. He always asks an examinee what condition he thinks he has. An examinee may or may not know his diagnosis. The examinee's information "may or may not be relevant." RX 1, p. 92. The term "golfer's elbow" refers to medial epicondylitis while the term "tennis elbow" refers to lateral epicondylitis. RX 1, p. 92.

Dr. Neal testified he has seen carpal tunnel syndrome develop due to a single event. RX 1, pp. 97-98. Carpal tunnel syndrome can result from repetitive trauma. RX 1, p. 98. The job-related document he reviewed appears to have been authored by "K. Travis." He does not know who this is. RX 1, p. 100. The document appears to be less of a job description and more

of a list of steps to take when performing a particular task. RX 1, p. 102. He has never seen or tested the equipment Petitioner worked on. He does not know how long Petitioner's shifts were. RX 1, p. 103. He has no idea how many screws Petitioner had to tighten per hour or day. Nor does he know who often Petitioner performed fine manipulation or pinching. He is "probably" aware Petitioner had only one 30-minute break per day. He does not know whether Petitioner was afforded only 58 seconds to work on one car. RX 1, p. 104. He presumes Petitioner had to lift catalytic converters at times. He does not know the weight of these items. Petitioner did not tell him she consistently used vibratory tools. RX 1, p. 105. If he asked her about this, he did not document it. RX 1, p. 106. It would not surprise him if Petitioner used air tools. RX 1, p. 106. He does not believe such tools are heavy because they are suspended in the air. RX 1, p. 106. He does not know if Petitioner had to grasp with both hands. He did not document any hobbies Petitioner might engage in outside of work. RX 1, p. 107. Rotational torqueing is generally not a force associated with the development of carpal tunnel syndrome. RX 1, p. 108. The literature is "split" as to whether the use of vibratory tools can cause the conditions Petitioner claims. RX 1, pp. 108-109. Hypothetically, and generally speaking, certain jobs can cause an underlying condition to permanently worsen. RX 1, p. 109. The use of vibratory tools could put Petitioner at risk, assuming the use was significant and required "significant positions of flexion and extension." Dr. Neal testified he does not have enough information to answer the question with greater specificity. Fine manipulation, in contrast, would "absolutely not" put Petitioner at risk. Petitioner's gender is a risk factor but she does not have other risk factors such as diabetes, a thyroid disorder or rheumatoid arthritis. Nor is she pregnant. RX 1, pp. 111, 113. As for smoking, he cannot recall whether the literature identifies it as a risk factor. RX 1, p. 111. His report reflects that Petitioner uses tobacco products. RX 1, p. 112.

Dr. Neal testified Petitioner is "not a malingerer." He believes she has problems. RX 1, p. 114.

Dr. Neal testified that Petitioner never described herself as performing one job function over and over. Her job duties were varied. It "may or may not" matter whether Petitioner's jobs varied if all of them required repetitive tasks. RX 1, p. 116. It is "closer to true than not" that he does not know the specifics of each job Petitioner performed. RX 1, p. 117. The fact he cannot reach a single diagnosis does not mean Petitioner has no symptoms. RX 1, p. 118. He believes Petitioner's psychosocial issues "absolutely explain a lot." RX 1, p. 118.

Dr. Neal expressed agreement with the premise that the medical literature does not definitely state carpal tunnel syndrome cannot be caused by repetitive trauma. RX 1, p. 128. He acknowledged the syndrome can be caused by such trauma, "under some circumstances." RX 1, p. 128. A female who works on an assembly line could develop carpal tunnel syndrome due to her work activities. RX 1, p. 130. For example, a female worker who was required to constantly hyperflex her wrist and squeeze grippers to cut thick cables could develop carpal tunnel syndrome. RX 1, p. 130. He cannot say whether outside activities contributed to Petitioner's condition because he did not document any such activities. RX 1, p. 132.

Dr. Neal found a "zero percent causal relationship" between Petitioner's work and her upper extremity conditions. RX 1, p. 135.

On redirect, Dr. Neal reiterated that the records he reviewed support the conclusion that Petitioner underwent care for both of her upper extremities before August 22, 2013. RX 1, p. 136.

Petitioner testified her arms hurt all the time. She takes Vicodin prescribed by her personal care physician. She finds it difficult to shower, wash her hair, do the dishes and sleep. Any activity that requires her to extend her arms is painful. She can walk her dog but has to put the leash around her waist. She is not able to groom the dog on her own. She travels to Minnesota where her fiancée lives and finds the vibration of the vehicle very bothersome. She wants to undergo the surgery Dr. Fernandez has recommended.

Petitioner testified she has not worked for Respondent since January 18, 2017. She has not returned to work because Respondent told her to leave after she presented Dr. Fernandez's restrictions.

Under cross-examination, Petitioner acknowledged becoming a "floater" at some point. She was not sure whether she became a floater in November 2012. As a floater, she filled in for other employees. The duration of each "float" assignment depended on the duration of the absence of the person she was filling in for. About 90% of the jobs she performed involved attaching bolts. She used a "six gun" to attach and screw bolts. A "six gun" is a vibrating device with six pipes that turns. All of the jobs she performed required her to reach with both arms. As of September 24, 2012, bins had to be moved manually, every 25 minutes. No mechanical hoist or lift was available at that point. Every job she performed involved moving "stock." "Stock" included alternators, hoses and compressors. Only the heaviest type of stock, such as seats, was lifted via a hoist.

Respondent's counsel showed RX 2 to Petitioner. After looking at this exhibit, Petitioner testified she had no recollection of calling her physician on September 20, 2012. Petitioner testified she would not have used the term "Vicodin" when contacting her physician. She would have used the term "pain medication." She acknowledged calling her physician on September 26, 2012 and complaining of finger numbness secondary to moving bins.

Petitioner could not recall whether she worked steadily during the period between her two claimed accidents. She was unsure whether she took a leave beginning in January 2013. She did take time off from work because her father was sick and in and out of the hospital. She also took a month and a half off after her father died.

Petitioner denied having any hand pain or undergoing any hand X-rays before September 24, 2012.

Petitioner recalled returning to work after each of her surgeries. She was unsure, however, whether she worked between April and October 2016. She last worked in January 2017, at which point Respondent told her it would no longer provided accommodated duty. Since January 18, 2017, she has received $512 per week from Unicare. She is not sure whether the gross amount of each weekly payment was $690.

Petitioner testified she has been taking Vicodin on and off since September 2012. Drs. Legaspi and Morker prescribed this medication for her. She has some hobbies but, because she has three children, she has no time to pursue them. She used to make stained glass pieces but has not done so for a year and a half. This involves hand cutting small pieces of stained glass and soldering them together. She has a social media profile. She uses Facebook on her phone and computer but spends only ten minutes per day on this. She also uses Pinterest. She used to use Pinterest on her phone at work during breaks. She no longer performs many household chores. Her children, who are 17, 20 and 22 years old, live with her and do the chores.

On redirect, Petitioner testified she cannot recall what history she provided to her physician on September 20, 2012. The telephone note of that date (RX 2) reflects she mentioned having a work injury but indicated she had not yet reported this injury to her employer. She is not sure what injury the note refers to. She used to break her fingers at work "all the time." She typically did not see a doctor for this. She would just wear a brace. She acknowledged completing PX 9, a report concerning her accident. As of this date, she "couldn't take the pain anymore." The term "stock," as used at her job, refers to any car part. Smaller parts are kept in bins. Hoists are used to lift heavy parts, such as seats. All the tasks she performed at work were repetitive in nature. She cannot recall exactly when she last worked on a stained glass project but the last piece she made was composed of pre-cut pieces. She worked on stained glass projects during times when her hands felt better. She has not made any stained glass pieces since January 2017.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning her job duties was detailed and believable. No Respondent witness contradicted Petitioner's assertions concerning her lengthy workdays, the mandatory nature of her overtime hours, the need to manually start bolts and screws, the use of vibratory tools such as air guns and the fact that a new car came down the assembly line every 58 seconds.

Some of Petitioner's treatment-related testimony conflicts with her records. For example, under cross-examination, she denied having hand problems before September 24, 2012, but her records show she consulted Dr. Legaspi on April 27, 2012 due to unusual finger knuckle growth. The same records show that the doctor prescribed blood work and hand X-rays, both of which proved negative. Petitioner did not remember calling the doctor's office on September 20, 2012 (four days before her first claimed accident) to request pain medication

secondary to an unspecified "work injury" she had not yet reported to her employer. On redirect, she testified it was not uncommon for her to experience injuries at work. Records in PX 9 bear this testimony out. They reflect Petitioner reported minor head bumps, splinters, etc. RX 2.

The Arbitrator has considered the foregoing inconsistencies in assessing Petitioner as a witness. Overall, the Arbitrator found Petitioner credible. The records reflect Petitioner sought care for a hand-related problem in April 2012, before her first claimed accident, but it is possible Petitioner had no recollection of this, since the work-up she underwent at that time did not reveal any abnormalities. As for RX 2, it is not clear what type of "work injury" Petitioner was referring to when she phoned her doctor's office on September 20, 2012. If she was, in fact, referring to hand or arm problems, that does not eliminate the possibility of a specific left elbow injury at work four days later.

Respondent's examiner, Dr. Neal, did not find causation but acknowledged Petitioner "has problems" and is "not a malingerer." RX 1, p. 114. He attributed "a lot" of Petitioner's problems to "psychosocial issues," including use of narcotic pain medication, but never explained how such issues, assuming they exist, would result in discreet hand and arm complaints.

From the Arbitrator's perspective, Dr. Neal lost credibility when he admitted he does not know the specifics of the jobs Petitioner performed, particularly in light of his concession that causation depends on "what [the worker] is actually doing." RX 1, pp. 116-117. He agreed Petitioner "may have had symptoms while working." RX 1, pp. 119, 124.

Dr. Neal exhibited potential for bias when he acknowledged that more than 95% of the examinations he performs are for employers rather than claimants. RX 1, p. 63.

Dr. Fernandez did not have a perfect understanding of the many tasks Petitioner performed at work but, overall, the Arbitrator found his opinions as to causation, treatment needs and work capacity more persuasive than those of Dr. Neal. The evidence shows Respondent authorized Petitioner's first visit to Dr. Fernandez as well as the three surgeries he performed. The payment of benefits is not an admission of liability but Respondent valued Dr. Fernandez's opinion sufficiently to arrange a consultation. Dr. Neal acknowledged he holds Dr. Fernandez in "high regard." RX 1, p. 54.

<u>Did Petitioner sustain accidents on September 24, 2012 and March 18, 2013 arising out of and in the course of her employment? Did Petitioner establish causal connection?</u>

Petitioner testified to specific accidents occurring on September 24, 2012 and March 18, 2013. Petitioner's testimony concerning these accidents was credible and supported by written accident reports appearing in PX 9. Petitioner reported a left elbow injury on September 24, 2012 and right hand and arm injuries on March 18, 2013. Notice is not in dispute.

The Arbitrator finds that Petitioner established accident in each case. The Arbitrator views the specific traumas of September 24, 2012 and March 18, 2013 as superimposed on underlying repetitive trauma injuries stemming from the assembly line work Petitioner performed for Respondent during various periods after being hired in 2010. In other words, the Arbitrator views Petitioner's claims as hybrid in nature, with both the specific events and the underlying job duties contributing to Petitioner's hand and arm conditions. This conclusion does not result in prejudice to Respondent. Dr. Neal clearly considered both specific and repetitive trauma theories in his reports and at his deposition. Caterpillar Tractor Co. v. Industrial Commission, 215 Ill.App.3d 229, 238 (4th Dist. 1991).

The Arbitrator further finds that Petitioner established causal connection in each case. There is no evidence suggesting Petitioner had any hand or arm problems before she began working for Respondent in 2010. She passed a physical examination before being put to work and completed forms denying any hand or arm symptoms. She reported some knuckle-related symptoms to her primary care physician in April 2012, but was not diagnosed with any condition at that time. She was able to continue working and did not again see a doctor for hand-related care until after her accident of September 24, 2012. The Arbitrator acknowledges there were some breaks in Petitioner's employment due to treatment of a non-work-related plantar wart condition and her father's illness but the evidence establishes a pattern of Petitioner's hand and arm conditions worsening during the periods she worked.

As indicated above, the Arbitrator has elected to assign greater weight to the causation opinions of Dr. Fernandez than to those of Respondent's examiner, Dr. Neal. Dr. Neal "hang his hat," so to speak, on the fact that Petitioner performed various assembly-related tasks, rather than one task over and over. Dr. Fernandez disagreed, accurately noting that, while Petitioner's job title might have changed, particularly when she worked as a "float," the physical tasks she performed required repetitive and forceful use of both hands. Dr. Neal targeted genetic factors. Dr. Fernandez conceded that some of these factors, including gender and age, exist, but both doctors agree Petitioner does not have other potentially contributing conditions such as diabetes, a thyroid disorder or arthritis. Dr. Fernandez further persuaded the Arbitrator when he explained that Petitioner's conditions are likely not idiopathic since they are bilateral and involve the elbows as well as the hands.

The Arbitrator does not view Petitioner's outside stained glass hobby as a significant contributing factor. It is not possible to rationally equate the activities associated with that hobby with the activities Petitioner performed during her lengthy workdays at Respondent. Moreover, a claimant in Illinois need only prove that her work was a causative factor. She need not eliminate all other possible contributing causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003).

Is Petitioner entitled to temporary total disability benefits? Is Respondent entitled to Section 8(j) credit?

The Arbitrator has found in Petitioner's favor on the issues of accident and causal connection. The Arbitrator has also elected to rely on Dr. Fernandez, Petitioner's surgeon, rather than Dr. Neal, Respondent's examiner, with respect to causation, treatment needs and work capacity. The Arbitrator views Petitioner's causally related right elbow condition as unstable as of December 2016, the point at which Dr. Fernandez recommended additional right elbow surgery. Petitioner testified she stopped working for Respondent as of January 18, 2017, at which point she was told Respondent would no longer provide accommodated duty. There is no evidence indicating Respondent extended an offer of light duty after January 18, 2017.

The Arbitrator awards temporary total disability benefits from January 18, 2017 through the hearing of June 21, 2017, a period of 22 1/7 weeks. The Arbitrator awards these benefits in the second case, 15 WC 15564, since the pending surgery involves the right elbow. The Arbitrator declines to award specific 8(j) credit to Respondent. Petitioner stipulated to receiving certain weekly payments from Unicare (Arb Exh 1) but Respondent failed to prove the exact period of these payments and whether the payments entitled it to credit under 8(j). It has long been held that an employer has the burden of proofs when it comes to establishing credit under Section 8(j). Hill Freight Lines, Inc. v. Industrial Commission, 36 Ill.2d 419, 414 (1967).

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims an unpaid balance in the amount of $166.00 relating to her office visit to Dr. Fernandez on September 1, 2015. PX 4. The Arbitrator has already found in Petitioner's favor on the threshold issues of accident and causation. The Arbitrator has also elected to rely on Dr. Fernandez's opinions as to treatment needs. The Arbitrator awards Petitioner the $166.00 office visit bill, subject to the fee schedule. The Arbitrator awards this bill in the second claim, 15 WC 15564, since the visit followed the right-sided surgery of April 2015.

Is Respondent liable for the Grzesik & Associates bill?

As noted above, Thomas Grzesik, a certified vocational rehabilitation counselor, conducted an interview and testing of Petitioner on June 14, 2016, at the request of Petitioner's counsel. PX 6. Petitioner seeks an award of Grzesik's $2,079.68 bill. PX 7.

Grzesik's report reflects that Petitioner reported last performing light duty for Respondent on April 18, 2016 and encountering difficulties getting back in to see Dr. Fernandez due to lack of authorization. PX 6, p. 9.

The Arbitrator notes that Grzesik assessed Petitioner about three months before Dr. Neal's examination took place and about six months before Dr. Fernandez re-evaluated Petitioner and recommended additional right elbow surgery.

There is no evidence indicating Respondent ever conducted a vocational assessment, as required by the Rules Governing Practice Before the Workers' Compensation Commission. In

Ameritech Services, Inc. v. IWCC, 389 Ill.App.3d 191, 207-208, the Appellate Court interpreted the applicable rule as requiring preparation of a written vocational assessment "even in circumstances where no plan or program of vocational rehabilitation is necessary or appropriate." Under Ameritech, Respondent was obligated to prepare an assessment even if it disagreed with the need for restrictions.

The Arbitrator finds Respondent liable for the $2,079.68 bill. The Arbitrator awards this bill in the second case, 15 WC 15564.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and casuation. The Arbitrator has also elected to rely on Dr. Fernandez rather than Dr. Neal. The Arbitrator views Dr. Fernandez's recommendation of additional right elbow surgery as reasonable, given the objective symptoms, including the ulnar nerve subluxation, the doctor noted when he re-examined Petitioner in December 2016.

The Arbitrator awards prospective care in the form of the additional right elbow surgery prescribed by Dr. Fernandez. The Arbitrator makes this award in the second case, 15 WC 15564.

Is Respondent liable for penalties and fees?

On May 9, 2017, Petitioner filed a 19(b)/8(a) petition along with a petition for penalties and fees. PX 10. Petitioner maintains Respondent is liable for penalties and fees based on the following: 1) its denial of prospective surgery and 2) its failure to pay temporary total disability benefits since January 18, 2017. Respondent maintains it reasonably relied on the opinions of its examiner, Dr. Neal, in disputing accident and causation and asserting that Petitioner needs no care and can perform full duty.

With respect to Petitioner's first contention, the Appellate Court has held the Commission has no statutory authority to award penalties based on an employer's denial of prospective care. Hollywood Casino – Aurora, Inc. v. IWCC, 2012 IL App (2d) 110426WC.

As for the second contention, Respondent authorized three surgeries and paid temporary total disability benefits, even after Dr. Neal's September 2016 examination. Respondent discontinued the payment of these benefits in January 2017 but, as Petitioner acknowledged, began paying non-occupational disability benefits. On this record, the Arbitrator declines to award penalties and fees.

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

MANOS, DEBRA
Employee/Petitioner

Case# **15WC015564**
15WC015563

FORD MOTOR COMPANY
Employer/Respondent

18IWCC0325

On 9/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

2194 STROM & ASSOCIATES
NEAL B STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

0560 WIEDNER & McAULIFFE LTD
DANIEL A BRAINARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

Debra Manos
Employee/Petitioner

v.

Ford Motor Company
Employer/Respondent

Case # 15 WC 15564

Consolidated cases: 15 WC 15563

18IWCC0325

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 18, 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 $**27,444.19**; the average weekly wage was $**623.73**.

On the date of accident, Petitioner was **49** years of age, *married* with **3** dependent children.

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

The parties agree Respondent paid $15,811.93 in temporary total disability benefits before the disputed period of January 18, 2017 through June 21, 2017. The parties also agree Respondent paid $26,772.50 in non-occupational indemnity disability benefits, although Petitioner disputes whether Respondent is entitled to Section 8(j) credit for this payment. Arb Exh 1.

ORDER

Respondent shall pay the $2,079.68 bill from Grzesik & Associates (PX 7).

Respondent shall pay the $166.00 bill from Midwest Orthopaedics (Dr. Fernandez) relating to Petitioner's office visit of September 1, 2015, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits in the amount of $415.82 per week from January 18, 2017 through the hearing of June 21, 2017, a period of 22 1/7 weeks.

Petitioner is entitled to prospective care in the form of the right elbow surgery recommended by Dr. Fernandez.

For the reasons set forth in the attached decision, the Arbitrator finds that Respondent failed to prove entitlement to a specific Section 8(j) credit. Hill Freight Lines, Inc. v. Industrial Commission, 36 Ill.2d 419, 424 (1967).

For the reasons set forth in the attached decision, the Arbitrator declines to award penalties or 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.

Molly C Mason

Signature of Arbitrator

8/11/17
Date

ICArbDec19(b)

SEP - 5 2017