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)
WILLIAMSON		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Hobbs,

Petitioner,

vs. NO: 16WC 29770

State of Illinois/Shawnee Correctional Center,

Respondent.

18IWCC0539

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 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 March 9, 2018, 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: SEP 4 - 2018
o080718
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOBBS, JOHN
Employee/Petitioner

Case# **16WC029770**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0539

On 3/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAR 9 - 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

JOHN HOBBS
Employee/Petitioner

v.

STATE OF ILLINOIS/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

Case # 16 WC 29770

Consolidated cases: _____

18IWCC0539

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **October 11, 2017**. By stipulation, the parties agree:

On the date of accident, **September 5, 2016**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$99,848.24**, and the average weekly wage was **$1,920.16**.

At the time of injury, Petitioner was **28** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

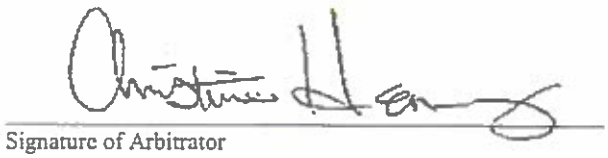
Respondent shall pay Petitioner the sum of $775.18/week for a further period of 64.5 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 30% loss of use of the left leg.

Respondent shall pay Petitioner the sum of $775.18/week for a further period of 50 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 10% loss of use of the body as a whole.

Respondent shall pay Petitioner compensation that has accrued from April 11, 2017, through October 11, 2017, and shall pay the remainder of the award, if any, in weekly payments.

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

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



Signature of Arbitrator

March 6, 2018
Date

MAR 9 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

18IWCC0539

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

JOHN HOBBS
Employee/Petitioner

v. Case #: 16 WC 29770

STATE OF ILLINOIS/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on September 5, 2016, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 28 years old, married, and had one dependent child. He was employed by Respondent as a Correctional Lieutenant. Petitioner testified that on September 5, 2016, he was engaged in tactical combat practice when a blue cushioned mat slid out from underneath him and caused him to fall. He injured his left knee and left shoulder as a result. He denied any prior injuries, treatment, or claims for his left knee or left shoulder.

Following the accident, Petitioner presented to the emergency room at Heartland Regional Medical Center on September 5, 2016. He complained of left knee pain, which he rated at 5/10. X-rays were negative for fracture, but showed joint effusion. An MRI was recommended to evaluate potential meniscal tearing. Petitioner's left knee was immobilized and he was given crutches and pain medication. He was instructed to follow up with his physician. PX3.

On September 13, 2016, Petitioner presented to Dr. Nathan Mall at The Orthopedic Center of St. Louis. He reported a consistent history of the accident and noted he hyperflexed his left knee and landed with his left arm extended behind him. He complained of left knee pain, mostly on the medial side of the knee, and left shoulder pain with difficulty with extension and overhead and significant weakness. Physical examination of the left knee demonstrated posteromedial bruising in the hamstring area, pain to palpation along the medial joint line, positive McMurray, palpable joint effusion, and some laxity with ACL testing with a 1B Lachman maneuver. Examination of the left shoulder showed limited active range of motion, pain to palpation over the biceps tendon, and positive O'Brien's test. Dr. Mall assessed a possible left shoulder rotator cuff

tear and/or SLAP tear and a possible left knee medial meniscus tear. He recommended MRIs of both the left shoulder and left knee. PX4.

On September 21, 2016, Petitioner underwent both MRIs at MRI Partners of Chesterfield. The left knee MRI revealed (1) ACL transection; (2) Grade III tear of the MCL with underlying disruption of the meniscal femoral struts causing an unstable meniscus; and (3) osteochondral impact injuries of the anterior weight bearing lateral condyle and far posterior lateral tibial plateau with intense underlying subcortical marrow edema. The left shoulder MRI revealed (1) circumferential labral tear with type III bucket-handle superior labral tear and inferior labral maceration; and (2) upper subscapularis intrasubstance tear with anterior medial subluxation of the biceps long head at the top of the groove. PX6. Dr. Mall reviewed the films. His assessment was left knee ACL tear and left knee MCL tear, and left shoulder bucket-handle type superior labral tear. He recommended surgery for both the left knee and the left shoulder. PX4.

On October 6, 2016, Petitioner underwent left knee arthroscopy with ACL reconstruction and medial meniscus repair. Intraoperative findings demonstrated blood around the area of Petitioner's ACL tear with a clear rupture of the ACL at its midpoint, a medial meniscal tear, and MCL tearing with instability. PX7. Petitioner followed up with Dr. Mall on October 11, 2016. He was given a brace for his knee and prescribed physical therapy for range of motion, stretching, and some strengthening. PX4.

Petitioner returned to Dr. Mall on November 8, 2016, and reported he was making significant improvement with physical therapy. Dr. Malls recommended waiting for the shoulder surgery until Petitioner had a little more physical therapy and was out of his brace. PX4.

On December 1, 2016, Petitioner underwent left shoulder surgery consisting of arthroscopy with debridement of the superior labrum, subacromial decompression and acromioplasty and open biceps tenodesis. Intraoperative findings confirmed a superior labral tear with extension into the biceps tendon, along with Grade IV cartilage changes to the glenoid and humeral head and an acromial spur. PX7. Petitioner followed up with Dr. Mall on December 13, 2016, and reported he already noticed some improvement in his shoulder pain. He was prescribed physical therapy for range of motion and strengthening. He was also to continue therapy for his knee. PX4.

Petitioner returned to Dr. Mall on January 10, 2017, and it was noted that he was progressing appropriately with both the knee and the shoulder. He was to continue physical therapy and was allowed to begin jogging. He followed up on February 14, 2017, and reported he had a bout of some tendinitis with respect to his left shoulder but had gotten past it and was again making improvements. He reported that his left knee did not bother him and he was already running about five miles at a time and doing so at a decent pace. Dr. Mall recommended continued strengthening for the shoulder and prescribed an anti-inflammatory. With regard to the knee, he recommended an ACL brace and continued strengthening and specific exercises to assist with Petitioner's job duties. PX4.

On March 20, 2017, Petitioner returned to Dr. Mall and reported he was struggling somewhat with physical therapy as respects his shoulder. On examination, there was limitation in range of motion. Assessment was inflammation and Dr. Mall administered a cortisone injection

to the left shoulder. Petitioner was to continue physical therapy for range of motion and strengthening. PX4.

Petitioner returned to Dr. Mall on April 11, 2017, and reported he was doing well with minimal complaints. He advised that the injection gave him "substantial relief and improvement in his range of motion and pain". On examination, he had near-normal strength and some decreased range of motion of the left shoulder. He was instructed to continue his home exercises for range of motion and strengthening. Dr. Mall released him to full duty work and placed him at maximum medical improvement. PX4.

On July 7, 2017, Petitioner was evaluated by Dr. Richard T. Katz, Respondent's Section 12 examiner. He stated that his left shoulder was causing him the most difficulty, including difficulty with over the shoulder activities, and reported a pain score of 4/10. He noted that his left knee affected his ability to run but he had no limitations on walking, and he had only very mild pain that day. Examination of the left shoulder showed a decreased range of motion as compared to the right. Diagnoses were superior labral tear, chondral changes to the glenoid and humeral head, subacromial spur, and subacromial bursitis. Dr. Katz provided an AMA rating of 15% impairment of the left upper extremity. Examination of the left knee was normal, except for mild laxity. Diagnoses were ACL tear, MCL tear, and medial meniscus tear. Dr. Katz provided an AMA rating of 10% impairment of the left lower extremity. RX2.

Petitioner testified at arbitration that with regard to his left shoulder, he continues to have weakness and difficulty with overhead work, and the shoulder catches occasionally. He has difficulty holding his arm out above his head at an angle. He is no longer able to engage in his former hobby of rock climbing, and his ability do housework has also been adversely affected. He continues to have occasional pain and takes Naprosyn for his symptoms. With regard to his left knee, Petitioner described it as "pretty arthritic" and "very stiff" in the mornings. He has pain after standing or walking for a period of time. He testified that his knee is sore and tender at the end of his shift and he notices a limp, particularly if he works a double shift. He wore a brace for a year following the injury per the instructions of Dr. Mall. He testified that his competitive running has been impacted, as his running times are now slower than they were prior to his injury. He continues to be a part of the tactical team at work.

On cross-examination, Petitioner testified he is currently working full duty and is not under the care of any doctor. He is not currently using any sort of device or brace. He testified he is able to satisfactorily perform his job duties and has had no complaints from any supervisors regarding his job performance since he returned to work.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, Respondent submitted an impairment rating performed by Dr. Katz, who provided an impairment rating of 10% of the left lower extremity and 15% of the left upper extremity. The Arbitrator places significant weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Correctional Lieutenant at the time of the accident and was ultimately able to return to work in that capacity without any restrictions as a result of said injuries. He continues to be part of the tactical team as well. He testified he performs all of his duties, though has pain and tenderness at the end of his shift. The Arbitrator places greater weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 28 years old at the time of the injury. He is obviously very young, and has many work years ahead of him, during which he must deal with his disability in two major joints. Over time his condition could improve, stay the same, or get worse. The Arbitrator places greater weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, there was no evidence that Petitioner's future earning capacity has been or will be impacted as a result of this injury. As such, the Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner sustained a left shoulder superior labrum tear extending into his biceps tendon. He also sustained left knee tears of the ACL, MCL, and medial meniscus. All of these injuries required surgical repairs, and the left shoulder required an additional post-operative injection. Petitioner has returned to work, including participation on the tactical team, and has resumed running competitively. He had to give up his hobby of rock climbing, and he has trouble doing work around his home. With regard to his left shoulder, Petitioner testified he continues to have weakness and difficulty with overhead work, and the shoulder catches occasionally. He has difficulty holding his arm out above his head at an angle. He continues to have occasional pain and takes Naprosyn as needed. With regard to his left knee, Petitioner described it as "pretty arthritic" and "very stiff" in the mornings. He has pain after standing or walking for a period of time. He testified that his knee is sore and tender at the end of his shift and he notices a limp, particularly if he works a double shift. He wore a brace for a year following the injury per the instructions of Dr. Mall, but currently does not wear it. The Arbitrator finds Petitioner's current complaints to be credible and corroborated by the treating medical records. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 30% loss of use of the left leg (64.5 weeks) pursuant to Section 8(e) of the Act, and a 10% loss of use of the body as a whole (50 weeks) pursuant to Section 8(d) 2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,920.16. The Arbitrator finds his permanent partial disability rate is $775.18, the maximum rate in effect for his date of accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerome Warner,
Petitioner,
vs.

NO: 14WC 00217

18IWCC0540

International Masonry Institute,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 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: SEP 4 - 2018
o082918
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARNER, JEROME
Employee/Petitioner

Case# **14WC000217**

INTERNATIONAL MASONRY INSITITUTE
Employer/Respondent

18IWCC0540

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON LAW FIRM
JACK CANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
KENNETH F SMITH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JEROME WARNER
Employee/Petitioner

v.

INTERNATIONAL MASONRY INSTITUTE
Employer/Respondent

Case # **14**WC **00217**

Consolidated cases: _____

18IWCC0540

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 **DOHERTY** Arbitrator of the Commission, in the city of **NEW LENOX**, on **5/16/2017**. 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 9/23/2011, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ 85,280.00; the average weekly wage was $1,640.00.

On the date of accident, Petitioner was 52 years of age, *married* with 0 dependent children.

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

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

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

Respondent is entitled to a credit of $11,078.86 under Section 8(j) of the Act. ARB EX 1.

ORDER

RESPONDENT SHALL PAY PETITIONER THE REASONABLE, NECESSARY AND CAUSALLY RELATED MEDICAL EXPENSES INCURRED IN THE CARE AND TREATMENT OF HIS INJURY PURSUANT TO SECTIONS 8 AND 8.2 OF THE ACT. SEE DECISION

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY OF $1,093.33 PER WEEK FOR A PERIOD OF 6-6/7 COMMENCING OCTOBER 17, 2015 THROUGH DECEMBER 3, 2015

RESPONDENT SHALL PAY PETITIONER $695.78 PER WEEK FOR 125 WEEKS AS PETITIONER SUSTAINED 25% LOSS OF USE OF THE PERSON AS A WHOLE PURSUANT TO SECTION 8(D)(2) OF THE ACT.

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

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

Evelyn R. Cheesy

Signature of Arbitrator

6/21/17
Date

JUN 26 2017

FINDINGS OF FACT

Petitioner, Jerome Warner is a tile mason. Petitioner testified that on September 23, 2011, Petitioner was employed as an instructor for Respondent, International Masonry Institute. As an instructor for Respondent, Petitioner's job duties included instructing masonry apprentices on the means and methods of the trade. The Petitioner's job duties require him to bend down and kneel down while instructing apprentices on how to perform certain aspects of their trade. (REX#3, pg. 22). The Petitioner's job duties also require him to setup and maintain a training system according to IMI Standards & Specifications. (REX#3, Ex. 1). These duties require Petitioner to prepare and handle various equipment, including straight edges.

Respondent did not dispute accident at trial. ARB EX 1. Petitioner testified that on September 23, 2011, he was in a store room getting supplies together for class later that morning. As Petition descended a ladder, a box containing 24 straight edges fell from the top of the 10-foot shelf and struck his head, neck, shoulder and back. The Petitioner is six feet tall. PEX#9 is a box of straight edges. It is 6 feet long and 4 inches in diameter. Each box weighs approximately 20 – 25 pounds. The Petitioner braced himself by holding the ladder. The Petitioner suffered a laceration at the top of his head.

Immediately following the accident, Petitioner noticed pain in his neck, shoulder, and upper back. He immediately contacted his supervisor, Jonas Elmore, and reported his injury. (REX #3, pg. 12). Mr. Elmore instructed Petitioner to seek treatment from their immediate care clinic, and to speak with Carol Majerowitz, who was responsible for workers' compensation for Respondent. (REX#3, pg. 12). Petitioner did as he was instructed and went to Immediate Care on September 23, 2011, complaining of neck pain. (REX#1, EX. 2). Petitioner received stitches in his forehead and was returned to work. (PEX#2, pg. 8).

Petitioner testified that he continued to experience pain in his neck that did not subside following this occurrence. Petitioner testified that the pain ultimately prompted him to seek treatment from Dr. David Spencer from the Spine Center, S.C. Petitioner first reported to Dr. Spencer on October 26, 2011. (PEX#2, pg. 8). He had previously sought care from Dr. Spencer for unrelated low back pain in November 2008. Petitioner testified that he never received treatment, saw a doctor or experienced neck pain prior to his September 23, 2011 work injury. The Arbitrator notes here that Respondent does not dispute causal connection for an injury to Petitioner's neck but does dispute the extent of the injury and the need for the cervical surgery that was ultimately performed on Petitioner.

During Petitioner's initial consultation, Dr. Spencer noted that Petitioner suffered an injury on September 23, 2011 during the course of his employment after some product fell and hit him on the head while he was working. (PEX#2, pg. 8). Dr. Spencer diagnosed Petitioner with a cervical and lumbar strain noting that this orthopedic and neurologic exam and x-rays were unremarkable. (PEX#2, pg. 8). He recommended that Petitioner undergo a regimen of oral steroids, and perform his full activities. (PEX#2, pg. 9). He expected a full recovery with no additional need for diagnostic studies or treatment. PX 2, p. 9.

Petitioner returned to Dr. Spencer on November 19, 2011. The Petitioner complained of increased pain in his neck and low back, which radiated down into his left leg. (PEX#2, pg. 8). Given the increase in symptoms, Dr. Spencer recommended that Petitioner undergo a cervical and lumbar MRI to determine the cause of his pain symptoms. (PEX#2, pg. 8). Petitioner underwent the recommended MRIs on December 13, 2011 at Advocate Lutheran General. (PEX#2, 42-45). The cervical MRI revealed bulging discs at C4-C5 and C6-C7, as well as a superimposed left paracentral disc protrusion and severe central spinal stenosis and bilateral neural foraminal narrowing at C5-C6. The radiologist concluded multilevel disc degeneration and spondylosis with multilevel

disc bulging, and a superimposed left paracentral disc protrusion at C5-6. The lumbar MRI revealed disc bulges at the L4-L5 and L5-S1 levels.

Petitioner returned to Dr. Spencer with the results from his MRI scans on January 4, 2012. During this visit, Dr. Spencer interpreted the scans and noted degenerative changes in the cervical spine. He stated that based on the studies and physical situation Petitioner did not need surgery and that he could continue his regular work activities without any limitations. However, Dr. Spencer prescribed a conservative course of treatment, including physical therapy. (PEX#2, pg. 13). During his deposition in this matter, Dr. Spencer explained that although he did not recommend that Petitioner undergo surgery following his January 4, 2012 appointment, "other doctors would have looked at this MRI scan and said that he should have had [surgery] right then and there, but I elected not to..." (PEX#1, pgs. 17, 26). Petitioner returned to work pursuant to Dr. Spencer's orders.

Petitioner testified that he continued to experience pain in his neck and lower back, but continued performing his duties as a tile-setting instructor with Respondent from January 2012 through his next appointment with Dr. Spencer on November 7, 2013, 20 months later. At the visit of November 7, 2013, Dr. Spencer recommended that Petitioner undergo a course of physical therapy for his cervical spine for 12 sessions and continue his normal work status. (PEX#2, pg. 13). Respondent authorized this treatment on November 20, 2013. (PEX#2, pg. 47).

Respondent had Petitioner examined by Dr. Edward Goldberg on October 9, 2013 pursuant to Section 12 of the Act. (REX#1, Ex. 2). During Dr. Goldberg's examination, Petitioner stated that he suffered an injury at work when he was struck in the head by a box that fell from a shelving unit. (REX#1, Ex. 2). Dr. Goldberg reviewed Petitioner's MRIs and agreed that they revealed a disc herniation at C5-C6 and stenosis from C4-C5 through C6-C7. (REX#1, Ex. 2). Despite nearly two years passing since the date of the injury, Respondent's personally selected Section 12 examiner opined that the condition of Petitioner's cervical spine was caused by the September 23, 2011 work injury. (REX#1, Ex. 2, pg. 2). Dr. Goldberg recommended that Petitioner should undergo a course of physical therapy to address his pain. (REX#1, Ex. 2). This was the only time Dr. Goldberg examined Petitioner. When he was deposed in December 2014, Dr. Goldberg stated that he could not provide any further opinions on the current condition of Petitioner's cervical spine injury, because he had not examined him in over a year. (REX#1, pg. 21)

Petitioner began a course of physical therapy at Athletico pursuant to Dr. Spencer orders. (PEX#4). He attended 9 sessions at the Niles location between December 6, 2013 and January 17, 2014. (PEX#4, pg. 3). At his last session on January 17, 2014, Petitioner's therapist, Elizabeth McGuire, PT, opined that Petitioner "demonstrates minimal gains in ROM, strength, and pain reduction since starting therapy. He would greatly benefit from return to MD for follow up to determine future plan of care." (PEX#4, pg. 43). Petitioner complained to his physical therapist that his neck still hurt when he looked up and down and that the pain flared with heavy lifting. PX 4, p. 46.

On February 26, 2014, Petitioner returned to Dr. Spencer pursuant to his therapist's recommendation. Dr. Spencer noted that "Jerome has been plagued with neck pain ever since he got hurt at work on September 23, 2011." (PEX#2, pg. 17)). Dr. Spencer further noted "I have been treating him symptomatically and he has been trying to work through it; however he continues to have pain that is interfering with his work." (PEX#2, pg. 17). Upon physical exam, Dr. Spencer observed that flexion/extension of the cervical spine was moderately limited and painful. (PEX#2, pg. 17). Dr. Spencer opined that "previous diagnostic studies have demonstrated kyphotic deformity of the cervical spine with some stenosis. It is my opinion that it may be time to resolve this with surgery and therefore I am recommending a repeat MRI scan." (PEX#2, pg. 16-17).

The Petitioner returned to Dr. Spencer on July 23, 2014. (PEX#2, pg. 20). He noted that Petitioner continued to work through his persistent complaints of neck pain. (PEX#2, pg. 20). Dr. Spencer again recommended a cervical MRI and prescribed pain medication to Petitioner. (PEX#2, pg. 20). Petitioner ultimately presented to 3T Imaging in Morton Grove, Illinois on August 13, 2014 for the MRI of his cervical spine. (PEX#2, pg. 57). The MRI revealed a disc protrusion at C6-C7 with multilevel disc bulges, as well as mild spinal stenosis at C4-C7 with multilevel neural foraminal narrowing at multilevels. (PEX#2, pg. 57).

Petitioner returned to Dr. Spencer with the results of his MRI on August 20, 2014. Dr. Spencer noted that the MRI revealed a variety of disc abnormalities and spinal stenosis. (PEX#2, pg. 18). In an effort to alleviate Petitioner's pain symptoms, Dr. Spencer recommended that he undergo a cervical epidural steroid injection. (PEX#2, pg. 18).

On October 23, 2014, Petitioner present to Dr. Mehul Sekhadia at Advocate Lutheran General Hospital for pain management. At this initial consultation, Mr. Warner reported that he suffered an injury at work on September 23, 2011 when boxes fell on his head. (PEX#3, pg. 36). Petitioner advised that his hands and arms were tingling and that he had a pins and needles sensation in both hands. Upon physical examination, Dr. Sekhadia noted a decrease in the range of motion of Petitioner's cervical spine and that facet maneuvers were positive bilaterally with the concordant symptoms in his neck. (PEX#3, pg. 37). Under a diagnosis of cervical radiculopathy, cervical spondylosis, and cervical disc protrusion at C6-7, Dr. Sekhadia administered an epidural steroid injection to Petitioner's cervical spine and ordered him to return in three weeks. (PEX#3, pg. 37). Petitioner testified that the injection was very uncomfortable.

Petitioner returned to Dr. Sekhadia on November 18, 2014. (PEX#3, pgs. 40-41). At that visit, Petitioner reported that the October 23, 2014 injection provided him with 3 weeks of 100% pain relief, but his symptoms had subsequently returned. (PEX#3, pgs. 40-41). Dr. Sekhadia recommended that Petitioner undergo a second injection, and ordered him to follow-up upon approval from Respondent. (PEX#3, pg. 41). Petitioner underwent a second epidural steroid injection on December 4, 2014. (PEX#3, pg. 49). The Petitioner testified that he experienced no relief after the second injection.

On January 14, 2015, Petitioner returned to Dr. Spencer with ongoing complaints of pain, numbness, and tingling in his neck radiating down to his arms. (PEX#2, pg. 18). Dr. Spencer noted that Petitioner suffered from these symptoms since his work injury on September 23, 2011. (PEX#2, pg. 18). During this visit, Petitioner noted that the epidural steroid injections failed to provide him with substantial pain relief. (PEX#2, pg. 18). Dr. Spencer opined that Petitioner required another MRI in order to determine whether he was a candidate for surgical intervention. (PEX#2, pg. 18). Specifically, Dr. Spencer opined that Petitioner would likely need an anterior discectomy and fusion at the C4-C5 and C5-C6 levels. Dr. Spencer also recommended a cervical myelogram and post myelogram CT scan.

On May 18, 2015, Petitioner underwent a myelogram of the cervical and lumbar spine, as well as CT scans of the cervical and lumbar spine at Lutheran General Hospital. The myelogram revealed severe circumferential narrowing of the dural sac at L4-L5. (PEX#2, pg. 100). The CT of the cervical spine revealed disc bulges and spinal stenosis from C3-C7. (PEX#2, pg. 98). The CT scan of the lumbar spine revealed disc bulges from L3-S1 and spinal stenosis at L4-L5. (PEX#2, pg. 96). At the visit of May 27, 2015, Dr. Spencer noted his interpretation of the cervical testing to show a C6-7 nerve root compression due to a disc herniation and left sided C5-6 protrusion that was then currently without symptoms. He recommended guarded activity and symptomatic treatment with a possible need for future surgery at those levels. PX 2, p. 24. In July 2015, Dr. Spencer

recommended the surgery due to the continued complaints of neck pain radiating into both the right hand and left upper extremity, results of the objective tests, and failure of conservative treatment. PX 2, p. 24.

On October 12, 2015, Dr. Christopher Bergin performed an anterior cervical discectomy and decompression of the spinal cord and nerve roots at the C4-C5 and C5-C6 levels, as well as a anterior fusion at C4-C5 and C5-C6. (PEX#3, pgs. 10-11). Dr. Spencer assisted on this surgery. (PEX#3, pgs. 10-11). Petitioner remained inpatient at Lutheran General Hospital until October 13, 2015. Petitioner was ordered to remain off of work and return to Dr. Spencer a week later.

Petitioner returned to Dr. Spencer on October 21, 2015. (PEX#2, pg. 27). Dr. Spencer noted that Petitioner was doing well and removed his sutures and ordered an x-ray. (PEX#2, pgs. 27, 29). In a letter to Respondent on October 27, 2015, Dr. Spencer opined that that the October 12, 2015 surgery was necessary and related to his September 23, 2011 work injury. (PEX#2, pg. 28). Dr. Spencer ultimately returned Petitioner to work on December 3, 2015 with restrictions. (PEX#2, pg. 29).

Petitioner testified that after his injury but before his surgery, a period of 4 years, he had limited movement including problems in his neck while bending at work and while working on his knees. He testified that for years while working he took several breaks per day and had help from co-workers with lifting. He agreed he missed no time from work during the 4 years prior to surgery. Prior to surgery, he had difficulty driving and getting into small cars. He testified that his pain never went away between the accident and the surgery but he tried to keep working and put off surgery thinking his condition would improve or go away. He resigned from respondent in August 2014 and started working for Mr. David's flooring where he set tile for 4 months and then moved to field superintendant for the company. His tile duties included laying tile on floors and walls which he performed before his surgery in 2015.

Currently, Petitioner testified that he notices neck pain with movement and while driving as the ability to move his neck is restricted. He takes advil at night. Petitioner currently works as a business manager for the union at the administrative district council 1 of Chicago. His current job does not require him to move materials or lift materials. He is required to drive to various jobs in three counties 4 hours per day.

Petitioner's surgery was not approved by Respondent. The Petitioner put the bills through his group carrier. However, several bills incurred as a result of Petitioner's injury remain unpaid. Specifically, Dr. David Spencer and the Spine Center have an outstanding bill in the amount of $85,186.00 for services rendered from October 12, 2015 through December 7, 2015. (PEX#2, pgs. 6-7). Advocate Lutheran General, the surgery location, has an outstanding bill in the amount of $58,194.50 for services rendered from December 13, 2011 through October 13, 2015. (PEX#3, pgs. 3-9). Meyer Family Medicine, where Petitioner went for surgical clearance, has an outstanding bill in the amount of $760.0 for services rendered from October 7, 2015 through October 9, 2015. (PEX#5). Integrated Imaging Consultants has an outstanding bill in the amount of $559.00 for services rendered from May 18, 2015 through October 12, 2015. (PEX#6). Advocate Physicians Group has an outstanding bill in the amount of $1,428.00 for services rendered on October 12, 2015. (PEX#7). Dr. Gerald Zenk, the anesthesiologist who provided services during the surgery, has an outstanding bill in the amount of $4,185.00 for services rendered on October 12, 2015. (PEX#8).

Dr. Spencer testified via evidence deposition in July 2014, prior to Petitioner's cervical surgery in 2015. Dr. Spencer opined that Petitioner's pre-existing cervical degeneration was aggravated by the accident of 9/23/11. PX 1, p. 9, 17. He did not recommend cervical surgery in 2011 but noted that other doctors may have ordered surgery based on the MRI of December 2011. P. 17. Dr. Spencer opined that during the two years Petitioner worked between 2012 and 2014, his condition became progressively worse through a combination of his

original condition before he even got hurt, the traumatic aggravation and then his work activities subsequent to that. P. 18. Dr. Spencer testified that he thought Petitioner needed the cervical surgery in 2011 but that he decided not to recommend the surgery at that time. When asked if his causation opinion was affected by Petitioner's lack of treatment between 2012 and 2014 Dr. Spencer responded "The only significance of that is that he thought his condition was stable enough that he didn't have to see me and treat with me." P. 20. He noted that thereafter in February 2014, Petitioner returned and reported continued pain since the date of accident and that it now was interfering with his work. Dr. Spencer presumed from this note that Petitioner's pain had gotten progressively worse during the 2 year interval. P. 22. He further testified that he tries to deal with Petitioner's type of stenosis originally detected conservatively at first and then with surgery should conservative care fail. P. 23-26. He believes Petitioner tried to "tough it out" between 2012 and 2014 and then returned for care when he could no longer do so. P. 25.

Section 12 examining physician Dr. Goldberg testified via evidence deposition on December 8, 2014, also prior to Petitioner's cervical surgery. RX 1. He reviewed the December 2011 MRI and determined degenerative disc disease at C4-7 with spinal stenosis at C4-5 and C6-7 and a central and left sided disc herniation at C5-6. P. 11. With Petitioner reporting no prior cervical problems, Dr. Goldberg opined that the accident aggravated Petitioner's degenerative disc disease and sustained cervical strain without radicular pain or spinal cord involvement. He did not feel Petitioner was a surgical candidate when he examined him in October 2013. P. 11-12. Dr. Goldberg thought a month of physical therapy was appropriate. P. 13. Since Dr. Spencer saw Petitioner after his exam of Petitioner Dr. Goldberg deferred to Dr. Spencer on the need for surgery. He further testified that if Petitioner's symptoms and neurologic dysfunction deteriorated it may or may not be related to the original trauma and that surgery is dependent on the clinical picture presented at the time surgery is recommended. P. 15-16. Dr. Goldberg agrees the accident aggravated Petitioner's underlying stenosis and disc disease. P. 16. He further agreed that when he saw Petitioner in 2013, two years after the accident, Petitioner was not at MMI. P. 19-20.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

CAUSAL CONNECTION

The Arbitrator initially notes that accident is not at issue. ARB EX 1. The Arbitrator further notes that Respondent contests causal connection for Petitioner's cervical condition to the extent it required the surgery performed by Dr. Spencer. Based on a preponderance of the credible evidence at trial as noted above, the Arbitrator finds that Petitioner's cervical condition and the surgical repair performed by Dr. Spencer are causally related to his accident of 9/23/11. In so finding, the Arbitrator notes Petitioner's pre-existing degenerative spinal condition revealed on the initial MRI of December 2011. However, Petitioner's unrebutted testimony is that he had no prior complaints or cervical issues until he was struck on the head by the falling materials at work on 9/23/11. Thereafter, Petitioner sought conservative treatment from Dr. Spencer through January 2012 and continued working throughout. Petitioner testified that he continued to experience pain in his neck and lower back, but continued performing his duties as a tile-setting instructor with Respondent from January 2012 through his next appointment with Dr. Spencer on November 7, 2013, 22 months later. At the visit of November 7, 2013, Dr. Spencer recommended that Petitioner undergo a course of physical therapy for his cervical spine for 12 sessions and continue his normal work status. (PEX#2, pg. 13). Respondent authorized this treatment on November 20, 2013. (PEX#2, pg. 47). When Dr. Goldberg examined Petitioner in October 2013,

he agreed Petitioner was not at MMI and needed additional treatment for cervical symptoms which at that time he opined were the result of an aggravated preexisting condition.

The fact that Petitioner did not seek treatment from Dr. Spencer between January 2012 and November 2013 is not lost on the Arbitrator. However, the Arbitrator notes Petitioner's testimony that although he continued working, he did so because he was trying to work through the pain hoping the symptoms would go away. His unrebutted testimony is that the symptoms did not go away and were in fact worsening during this time period such that he returned to Dr. Spencer for additional treatment in November 2013. The Arbitrator is not persuaded to find this a "gap" in treatment sufficient to sever causal connection under the facts of this case. Petitioner credibly testified that his symptoms never improved, and in fact had been present since the accident in 2011. Dr. Spencer testified that he chose conservative care over surgical care in 2011 but that surgery was always an option from the start of treatment. When conservative care failed after an extensive time, he recommended and then performed surgery.

When Petitioner returned to Dr. Spencer on February 26, 2014, Dr. Spencer reported that "Jerome has been plagued with neck pain ever since he got hurt at work on September 23, 2011." (PEX#2, pg. 17) Dr. Spencer again noted that Petitioner complained of continuous neck pain following the September 23, 2011 work injury during Petitioner's July 23, 2014 and January 14, 2015 visits. (PEX#2, pg. 20, 18). Following the failure of physical therapy, Dr. Spencer recommended an alternative form of conservative treatment in the form of epidural steroid injections. Petitioner received epidural steroid injections through December 4, 2014. (PEX#3). The injections also failed to relieve Petitioner's pain.

Dr. Spencer testified that, in his opinion, Petitioner's cervical spine condition was caused by the September 23, 2011 work injury and that this work injury required surgical intervention. (PEX#2, pg. 28). Petitioner subsequently underwent an anterior cervical discectomy and decompression of the spinal cord and nerve roots at the C4-C5 and C5-C6 levels, as well as an anterior fusion at C4-C5 and C5-C6 on October 12, 2015. (PEX#3, pgs. 10-11). Respondent did not present an updated opinion from Dr. Goldberg on the need for surgery.

Respondent accepted the accident and admitted that Petitioner a neck injury. Petitioner had no history of neck pain before the September 23, 2011 work injury. Since that time, he has consistently reported neck pain at all of his doctors' visits. Based on this evidence, Dr. Spencer, Petitioner's treating physician, opined that Petitioner's cervical spine injury and subsequent cervical fusion were caused and necessitated by the September 23, 2011 work injury. Dr. Spencer opined that the Petitioner failed conservative care and needed surgery. Dr. Goldberg saw the Petitioner once and agreed with conservative care based on the December 2011 MRI findings. Dr. Goldberg never saw the Petitioner after he failed conservative care and in fact deferred to Dr. Spencer who saw Petitioner thereafter on the need for surgery. As such, the Arbitrator finds that Petitioner's condition of ill-being is causally related to his September 23, 2011 work injury.

OUTSTANDING MEDICAL BILLS

Respondent's dispute at the medical expenses is based on liability. Based on the findings on the issue of causal connection, the Arbitrator further finds that the treatment rendered to Petitioner from December 13, 2011 through December 7, 2015 was reasonable and necessary to treat Petitioner's causally related injuries. As such, Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in the care and treatment of his cervical condition pursuant to Sections 8 and 8.2 of the Act. PX 2-3 and 5-8. Respondent shall receive credit for amounts paid including credit under Section 8(j) of the Act and shall hold Petitioner harmless for same. ARB EX 1.

TEMPORARY TOTAL DISABILITY

Dr. Spencer ordered Petitioner to remain off work following his October 12, 2015 surgery. Dr. Spencer required Petitioner to stay off work from October 12, 2015 until December 3, 2015. (PEX#2, pg. 29). This evidence is without rebuttal. Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay the Petitioner the sum of $1,093.33 per week in temporary total disability for 6 - 6/7 weeks from October 17, 2015 through December 3, 2015.

NATURE AND EXTENT OF THE INJURY

The Petitioner testified he continues to experience pain and discomfort neck and into his arms and hands. Petitioner underwent an anterior cervical discectomy and decompression of the spinal cord and nerve roots at the C4-C5 and C5-C6 levels, as well as an anterior fusion at C4-C5 and C5-C6. (PEX#3, pgs. 10-11). He also received epidural steroid injections.

An AMA impairment rating was not done in this matter, however, Section 8.1(b) of the Act requires consideration of five factors in determining permanent partial disability:

1. The reported level of impairment;
2. Petitioner's occupation;
3. Petitioner's age at the time of the injury;
4. Petitioner's future earning capacity; and
5. Petitioner's evidence of disability corroborated by treating medical records.

Section 8.1(b) also states, "No single 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 a physician must be examined." Neither an AMA impairment rating nor a functional capacity evaluation were done in this case. During the trial of this case, Petitioner described the many difficulties he now experiences following his cervical fusion. However, because there is no reported objective findings of Petitioner's level of impairment, the Arbitrator places no weight on this factor.

Petitioner's Occupation

Petitioner is a cement mason by trade. At the time of his injury he was an instructor for Respondent. As an instructor for Respondent, Petitioner's job duties included instructing masonry apprentices on the means and methods of the trade. His job duties require him to bend down and kneel down while instructing apprentices on how to perform certain aspects of their trade. (REX#3, pg. 22). Mr. Warner's job duties also require him to setup and maintain a training systems according to IMI Standards & Specifications. (REX#3, Ex. 1). The training aspect of Petitioner's duties comprise 70% of his employment with Respondent. There is also an administrative aspect of Petitioner's duties as an instructor, but they only comprise 30% of his duties. Due to the physical job requirements of Petitioner's occupation, from which he eventually left, the Arbitrator gives some weight to this factor.

Petitioner's Age at the Time of Injury

Petitioner was 52 years old at the time of his injury on September 23, 2011. He was 56 years old at the time of his cervical fusion on October 12, 2015. He was 58 years old at the time of trial. The Petitioner's advanced age, combined with his specific training may limit his work ability in the future to some extent. The Arbitrator gives some weight to his factor.

Petitioner's Future Earning Capacity

Petitioner did return to work with Respondent as an instructor for some time but now works for a different employer as a business manager. Petitioner testified that he continues to experience pain and discomfort in his neck and arms following his cervical fusion and that he has difficulty driving which is required in his current job. However, the Arbitrator finds that the evidence at trial does not support an injury to Petitioner's future earning capacity and no weight is given to this factor.

Evidence of Disability Corroborated by Medical Records

Petitioner's medical records at PEX #2 PEX #3, and PEX #4, demonstrate that Petitioner attempted to work through the pain caused by the injury to his cervical spine. Petitioner provided consistent pain symptoms and history of injury throughout his medical records. He attempted to treat his symptoms through conservative methods including physical therapy and epidural steroid injections, which provided minimal relief. When conservative treatment proved ineffective, Petitioner underwent an anterior cervical discectomy and decompression of the spinal cord and nerve roots at the C4-C5 and C5-C6 levels, as well as an anterior fusion at C4-C5 and C5-C6. (PEX#3, pgs. 10-11). Despite this extensive medical treatment. Petitioner made a good recovery and was able to return to work as an instructor for Respondent and now work for a different employer. Petitioner testified that although he has been able to return to work he still experiences pain and discomfort in his neck and into his arms and hands. The Arbitrator gives great weight to this factor.

Weighing these five factors as stated above, the Arbitrator finds that Petitioner sustained 25% loss of use of the person as a whole pursuant to Section 8(d)(2) 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 WILLIAMSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wilbert Stephens,

Petitioner,

vs.

NO: 14WC 30406

The American Coal Company,

18IWCC0541

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 occupational disease (was there an exposure; was there a disease; did it arise out of employment; was it in the course of employment; what was the last date of exposure), causal connection, nature and extent, legal error, evidentiary error, Section 1(d) - Section 1(f) 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 12, 2018, 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.

18IWCC0541

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: SEP 5 - 2018
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LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STEPHENS, WILBERT
Employee/Petitioner

Case# **14WC030406**

THE AMERICAN COAL COMPANY
Employer/Respondent

18IWCC0541

On 1/12/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

18IWCC0541

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILBERT STEPHENS
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **14** WC **30406**

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 **November 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 **Disease, Causation and Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **February 5, 2013,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury the average weekly wage was **$1,388.81**.

On the date of accident, Petitioner was **63** 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 Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he suffered from any occupational lung disease, including coal workers' pneumoconiosis, that his condition of ill-being was causally related to his employment or that he suffered a timely disablement as defined in Section 1(e) of the Occupational Diseases Act. 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.

Melinda M. Pace-Sullivan
Signature of Arbitrator

1/10/18
Date

JAN 12 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Wilbert Stephens
Employee/Petitioner

Case # 14 WC 30406

v.

Consolidated cases: N/A

The American Coal Company
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The evidence reveals that Petitioner was 67 years old at the time of arbitration. He testified that he was married and lived in Harrisburg. He testified that he graduated from high school and then served two years in the Army. He testified that he worked about 38 years in the coal mine with almost all that time being underground. In addition to coal dust, Petitioner testified that he was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes.

Petitioner testified that his last day working underground in the coal mine was on February 5, 2013. He testified that he injured his back on that date and went off work for almost a year because of his back injury and surgery related to same. He testified that he went back to work in the guard shack on light duty. He testified that when he was released for full duty, he was going to have to go back to work below ground and just decided to retire. He testified that he knew he could not do the job anymore because he could not even touch his toes. He testified that sometimes he had to crawl on his hands and knees on the longwall. He testified that he was also having trouble with his breathing. He testified that he was 63 years old when he took his retirement. He testified that his job classification when he retired was that of a shield operator. He testified that he did not have any employment after the coal mine.

Petitioner testified that he started working in the coal mines in 1973 at North American Coal in Ohio and that when he first hired in, he worked on the belt. He testified that he would shovel coal back onto a conveyor belt and worked on putting belts back together. He testified that he worked there until 1986 when he was laid off. He testified that he then worked at Top Ford Auto as a mechanic for four or five months and then got a job at Kerr McGee, which later became Respondent. He testified that when he started for Respondent, he worked on the belts for almost two years and then was put on the longwall. He testified that as a shield man, he pulled the shields around the shear once the top was cut to hold the top up. He testified that he was right there where the coal was being cut out of the face. He testified that he would get dust exposure as the coal was being cut. He testified that this would be considered one of the dustier jobs in the mine and that he did that job for 28 or 29 years.

Petitioner testified that he first noticed breathing problems at work about five years ago. He testified that he was doing hard work and got dizzy and light-headed, and that could not get his breath very well. He testified that he told his boss he had to stop for a while. He testified that he had these problems while he was swinging a sledgehammer to break up rocks so they could move the longwall forward. He testified that from the time he first noticed his breathing problems until he left the mine, they got a little worse. He testified that since leaving the mine until the time of arbitration, his breathing has been about the same. He testified that he was not taking any breathing medications. He testified that he cannot work

as hard as he used to and that if he does, he gets really tired and winded. He testified that if he mows the lawn, he gets more tired than he used to and that he had to sit down and take a rest. He testified that he could climb two flights of stairs before he would have to stop and rest a little bit. He testified that he could walk on level ground at a normal pace about ¾ of a mile before he would have to stop and rest. He testified that one of his hobbies is working on cars and that his breathing does not bother him with that hobby unless he is picking up something heavy and moving it around. He testified that he goes camping twice each summer in his 17-foot camper and that he also helps take care of the house.

Petitioner testified that he started smoking when he was 19. He testified that he quit smoking when he started working in the mine. He testified that he has not smoked in 30+ years. He testified that when he was smoking, he smoked probably a pack a day.

On cross examination, Petitioner testified that he was 5'6" and weighed 150 pounds at the time of arbitration. He testified that when he last worked in the mine, he weighed about 140 pounds. He testified that he hurt his back on February 5, 2013 when he was lifting bags of rock dust, twisted and felt pain in his back. He testified that he continued to work light duty for a while after his injury until they could schedule his surgery. He testified that on light duty, he worked on the surface in the office. He testified that the shield man was a job that required heavy labor. He testified that after his back surgery with Dr. DeGrange, he was released back to what the mine called transitional duty. He testified that he came back at that time and worked in the guard shack checking people in and that he also swept the floor and washed the windows. He testified that Dr. DeGrange placed him at maximum medical improvement and placed a 40-pound lifting restriction on him. He testified that he did not feel that he could safely return as a shield man and decided to retire and that at that point in time, he signed up for Social Security and his pension.

On cross examination, Petitioner testified that he recalled one time undergoing chest x-ray screening for black lung by NIOSH. He testified that he did not recall getting an answer from them about what his chest x-ray revealed. Petitioner did not have any letters from NIOSH with him at the time of arbitration.

The transcript of the deposition of Dr. Glennon Paul was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Paul testified that he is the Medical Director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at SIU Medical School. He testified that he is the senior physician at Central Illinois Allergy and Respiratory Clinic. He testified that he is board-certified in allergy, immunology and asthma. (PX1).

Dr. Paul testified that Petitioner was a coal miner for 37 years. He testified that Petitioner indicated that he would get short of breath when he went up stairs and when he walked for a length of time, but that he could not be specific. When asked if it would be unusual for the coal miners he had treated not to have complained to their physicians about shortness of breath even though they had pneumoconiosis, Dr. Paul responded that the men did not complain and that it was not uncommon for them not to complain of shortness of breath when they had coal worker's pneumoconiosis. (PX1).

Dr. Paul testified that his diagnosis was that of coal worker's pneumoconiosis and that exposure to coal dust and the coal mine environment caused Petitioner's coal worker's pneumoconiosis. He testified that in light of his diagnosis of coal worker's pneumoconiosis, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. He testified that the pulmonary function test did not demonstrate any limitation to doing physical work, but that it was in his lungs and that at some time Petitioner may not be able to do physical activity. He testified that he has not seen Petitioner since February 3, 2015, but that normally "these guys" would get worse with time and may be so bad that they could not even walk across the room because of their shortness of breath induced by the chronic inflammation of coal dust in the lungs. (PX1).

Dr. Paul testified that when a coal miner of 20-25 years or more left the coal mine, they did not expel all the coal mine dust in their lungs and that some always remained for the rest of their lives. He testified that a person can have coal worker's pneumoconiosis despite having a negative chest x-ray. He testified that it was possible that if there was a biopsy or autopsy that showed there was coal worker's pneumoconiosis and during life there was a split opinion amongst the readers of the x-rays, it would confirm the positive readings. (PX1).

Dr. Paul testified that in order to have pneumoconiosis, one must have, in addition to coal mine dust deposited in the lungs, a tissue reaction to it called scarring or fibrosis. He testified that the scarring of coal worker's pneumoconiosis could not perform the function of normal healthy lung tissue. He testified that, by definition, if one had coal worker's pneumoconiosis, it was true that one necessarily had some impairment in the function of the lung at the site of the scarring whether it could be measured by spirometry or not. He testified that spirometry measured global impairment of the lung and that it was possible to have injury or disease in the lung despite having normal pulmonary function test results. He testified that a person can have shortness of breath despite having pulmonary function tests within the range of normal and that a person can have a lobe of a lung surgically removed and still have pulmonary function tests within the range of normal. (PX1).

Dr. Paul testified that if one wanted to know whether or not a specific exposure had caused impairment of a miner's lungs, one needed to have serial pulmonary function tests, pre-tests and post-tests. He testified that pulmonary function tests would tell you the type of abnormality, such as whether it was obstructive or restrictive and how severe it was, but that it would not tell you the etiology. He testified that emphysema in any of its forms, if significant enough to cause a measurable defect, would be obstructive. He testified that the scarring of pneumoconiosis could be both obstructive or restrictive. He testified that a person can have radiographically significant coal worker's pneumoconiosis and have normal pulmonary function testing, normal blood gases and a normal physical examination of the chest. (PX1).

Dr. Paul testified that coal worker's pneumoconiosis was considered to be a progressive disease and that with further exposure it could progress to progressive massive fibrosis or complicated pneumoconiosis which could be life-threatening. He testified that with further exposure, it can progress and involve the heart in a condition called cor pulmonale which is life-threatening. He testified that there was no cure for coal worker's pneumoconiosis. He testified that if a coal worker has coal worker's pneumoconiosis and ends his exposure to coal mine dust, it can still progress. He testified that if a person has coal worker's pneumoconiosis that is progressing, there is no way to stop the progression. He testified that if a coal worker has coal worker's pneumoconiosis, they cannot have further exposure to coal mine dust without endangering their health. (PX1).

Dr. Paul testified that generally, the progression of coal worker's pneumoconiosis was usually gradual and that when one first developed coal worker's pneumoconiosis it would come on so slow that one may have it for some time before it was recognized. He testified that there were exposures in the environment of a coal mine that could injure the lungs in addition to coal dust, including silica, diesel fumes, fumes from other petroleum products, smoke and fumes from sulfur coal fires, smoke and fumes from electrical cable fires, fumes from the glues used in the roof bolting process and welding fumes. (PX1).

Dr. Paul testified that COPD was an umbrella term for a number of obstructive diseases including emphysema, chronic bronchitis and asthma. He testified that when there was scarring in the lungs, it decreased the ability of the lungs to expand. He testified that obstructive lung disease was where the elasticity was gone, but that some of the small airways were destroyed like that which occurs with cigarette-induced emphysema. He testified that when a person has obstructive lung disease and the elasticity is destroyed, this can result in what a layman might call holes in the lungs or blebs. He testified that it can progress through a series of centrilobular, panlobular and all the way to bolus emphysema. He testified that bolus emphysema was represented by spaces in the lungs of one centimeter or larger. (PX1).

Dr. Paul testified that obstructive lung disease can be multiple factorial in origin, that the inhalation of coal mine dust can result in shortness of breath, chronic cough, emphysema and chronic bronchitis and that there were exposures in the environment of a coal mine that could result in occupational asthma. He testified that if an examining doctor had medical records on a miner, it could not change in any way what was seen on the x-rays. He testified that no matter what was contained in treatment records, it would not change the results obtained on pulmonary function testing nor what was found on physical examination. He testified that the records would not change the diagnosis based on his reading of the x-rays, the pulmonary function testing or the physical examination. (PX1).

Dr. Paul testified that if a person had chronic obstructive pulmonary disease or obstructive lung disease, the best medical practice was to avoid any further exposure to those agents that could cause or aggravate it. When asked how many years it took to develop coal worker's pneumoconiosis once one began to mine if a susceptible host, Dr. Paul responded that it varied from individual to individual. He testified that he was not a B reader. (PX1).

Dr. Paul testified that chronic bronchitis was one of the chronic obstructive pulmonary diseases and that one can have chronic bronchitis and have normal pulmonary function testing, normal blood gas testing and a normal physical exam of the chest. When asked if one had further exposure to coal mine dust after having chronic bronchitis and whether it can be a progressive disease, Dr. Paul responded that anything that one inhaled that was dusty, such as coal dust, could make a chronic bronchitis worse. He testified that reactive airway disease or asthma was characterized by asthma attacks or certain responses to triggers in the environment and that it was when one had a major infection or when one was exposed to a lot of dust, fumes, or odors that bronchospasm worsened. He testified that a restrictive airway disease could also be called bronchospasm. He testified that when one has a reactive airways disease, bronchospastic disease or asthma, the condition can be aggravated by the environment, dust, smoke and fumes of a coal mine. He testified that if a person has repeated bronchospasms or asthma attacks, there can be a medical phenomenon called remodeling in which their reactive airway disease can become a fixed obstruction. (PX1).

Dr. Paul testified that Petitioner could not have had any further exposure to coal mine dust without endangering his health. He testified that if a person has severe bronchospastic or reactive airway response to triggers in the environment, if serious enough it can be fatal. He testified that he reads approximately 100 chest x-rays per week and that he has been doing this for 35 years. He testified that when a coal miner leaves a coal mine after 20 years or more, they will have coal mine dust that stays trapped in their lungs that they cannot get out that will remain there for the rest of their life. He testified that the lung tissue that is next to the trapped coal mine dust will have exposure to coal mine dust for the rest of the miner's life and that that is one of the reasons that it can progress. (PX1).

Dr. Paul testified that if he read a person's x-ray as positive for coal worker's pneumoconiosis and they had enough exposures as a coal miner to cause coal worker's pneumoconiosis, this was a sufficient basis for him to make a diagnosis of coal worker's pneumoconiosis. He testified that a person can have coal worker's pneumoconiosis and have a normal chest x-ray. He testified that it can be found on both pathology and autopsy and not show up on x-ray. He testified that a negative x-ray cannot rule out of the existence of coal worker's pneumoconiosis. (PX1).

Dr. Paul testified that his board-certification is in internal medicine and allergy, immunology and asthma. He testified that he has been working in Springfield as a pulmonologist. He testified that he has been doing examinations to determine coal worker's pneumoconiosis for either federal or state cases for 35 years. (PX1).

On cross examination, Dr. Paul agreed that Petitioner was not his patient and that he saw him at a one-time visit at the request of his attorneys. He denied having reviewed any medical records for Petitioner.

He testified that he did not know whether Petitioner had undergone screening for black lung by NIOSH. He testified that Petitioner did not come to him with a past medical history of black lung. (PX1).

On cross examination, Dr. Paul agreed that Petitioner's complaint of shortness of breath on exertion could be something that was due to conditions other than pulmonary disease. He testified that Petitioner did not tell him that he retired at the time he did due to a breathing problem. He agreed that the only thing that Petitioner related to him that caused his shortness of breath was exertion. He agreed that his examination of Petitioner's chest revealed no signs of pulmonary disease. He testified that he did not remember the date of the chest x-ray that he reviewed. He testified that there was no problem with the film quality. (PX1).

On cross examination, Dr. Paul testified that he was neither an A or a B reader. When asked if he had taken the NIOSH course, Dr. Paul responded that he was not a radiologist. When asked whether one had to be a radiologist to take the course, Dr. Paul responded that he did not know but thought so. He agreed that he is not board-certified in pulmonary disease. He testified that he did not think that they had pulmonary boards in the early 1970's. (PX1).

On redirect, Dr. Paul testified that for 40 years he has been the medical director of respiratory therapy at St. John's Hospital and has been performing the work of a pulmonologist. He testified that for the first 10 of those years, he was also performing the same duties at Memorial Hospital. He testified that B reading was not taught, to his knowledge, in medical school. (PX1).

The X-ray Interpretation of Dr. Henry Smith dated October 27, 2014 and C.V. was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The impression was noted to be that of simple coal worker's pneumoconiosis with small opacities, primary p, secondary p, upper mid and lower zones bilaterally, profusion 1/0 for a date of radiographs of September 30, 2014. It was noted that Dr. Smith is a NIOSH Certified B-reader. (PX2).

The X-ray Interpretation of Dr. Alexander dated November 30, 2014 and C.V. was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The impression was noted to be that of coal worker's pneumoconiosis, category p/p, 1/0, aa, pa for a date of x-rays of September 30, 2014. It was noted that Dr. Alexander if a Certified Pneumoconiosis B reader. (PX3).

The medical records of Dr. James Alexander were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on February 9, 2011, at which time he was assessed with conjunctivitis and sinusitis. It was noted that Petitioner's lungs were clear to auscultation, no wheezing was heard, no rhonchi were heard and no rales/crackles were heard. At the time of the January 2, 2012 visit, it was noted that Petitioner was assessed with a lumbar strain and intervertebral disc degeneration. It was noted that Petitioner had normal breath sounds/voice sounds and that no rales/crackles were heard in his lungs. At the time of the January 16, 2012 visit, it was noted that Petitioner was seen in follow-up for his neck/back injury. It was noted that no dyspnea or cough was noted, normal breath sounds/voice sounds were observed and no rales/crackles were heard. At the time of the January 30, 2012 visit, it was noted that Petitioner's chief complaint was that of a cough and a temperature. No stridor was observed in the upper airway. (PX4).

The records of Dr. Alexander reflect that Petitioner was seen on June 20, 2013 for a head laceration. At the time of the June 27, 2012 visit, it was noted that Petitioner was seen for removal of his stitches. At the time of the February 6, 2013 visit, it was noted that Petitioner was seen for low back pain. It was noted that Petitioner had normal breath sounds/voice sounds. At the time of the February 11, 2013 visit, it was noted that Petitioner had no dyspnea and was referred to physical therapy for a lumbosacral sprain. At the time of the February 18, 2013 visit, Petitioner was seen for a recheck of his back. It was noted that Petitioner had no dyspnea, that he had normal breath sounds/voice sounds and that no rales/crackles were heard. At

the time of the April 17, 2013 visit, it was noted that Petitioner was seen for a history and physical related to a back fusion. It was noted that Petitioner had no dyspnea or cough, that his chest was normal to percussion, that normal breath sounds/voice sounds were heard, that no wheezing was heard, that no rhonchi were heard and that no rales/crackles were heard. The assessment was noted to be that of acute sinusitis and acute bronchitis. (PX4).

Included within the medical records of Dr. Alexander was an interpretive report for chest x-rays performed on July 11, 2006 at Harrisburg Medical Center, which were interpreted as revealing (1) negative chest; (2) category classifications 0/0. At the time of the October 30, 2017 visit, Petitioner was noted to have active problems of COPD, among other issues. It was noted that Petitioner reported dyspnea expressed as feeling short of breath during exertion, no hemoptysis and no wheezing. It was noted that Petitioner had dyspnea but no cough. It was noted that rales/crackles were heard, that the chest was normal to percussion, that normal breath sounds/voice sounds were heard, that no wheezing was heard and that no rhonchi were heard. It was noted that Petitioner now had emphysema and black lung. (PX4).

The Costs for Dr. Castle were entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The transcript of the deposition of Dr. Cristopher Meyer was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Meyer testified that he is a radiologist and is a B reader who is certified through December 31, 2018. He testified that he is board-certified in radiology. He testified that his current average work week involves looking at 200-250 chest x-rays per week and roughly 20-40 chest CT scans. (RX1).

Dr. Meyer testified that he reviewed films dated September 30, 2014 from Central Illinois Allergy and Respiratory for Petitioner and that the films were of diagnostic quality, but were Quality 3 due to poor contrast and mottle. He testified that mottle can simulate small opacities, such as small pinpoint opacities that have an appearance similar to size P opacities. He testified that there was a linear opacity at the left lung base that was either atelectasis or scarring and that the lungs were otherwise clear without small opacities and that there was some calcification indicating atherosclerosis in the aorta. He testified that his impression was that there was no finding of coal worker's pneumoconiosis in the lungs. He testified that the differential was scarring that probably would have resulted from a little focus of pneumonia previously and that coal dust exposure typically gave one a more diffuse interstitial lung process, while this was a very focal process in the lungs. (RX1).

On cross examination, Dr. Meyer agreed that NIOSH does not accept CT scans for the purpose of making B-readings. He agreed that in comparison to an analog chest x-ray, a CT scan was pretty expensive. He agreed that when comparing the radiation, the exposure of a CT to an analog x-ray revealed about 100 times more radiation in the CT but that the number was steadily declining with better technology. (RX1).

On cross examination, Dr. Meyer agreed that when one wanted to determine the existence of lung disease, it was true that the gold standard was pathologic review of the tissue itself rather than radiology. He testified that his assumption when he is asked to do a B-reading is that the worker has an appropriate exposure history to warrant having the chest x-ray so he is looking for pneumoconiosis and wants to interpret that as objectively as possible. He testified that there could be disagreement amongst B-readers as to whether they thought they were seeing opacities or not and that making the distinction between 0/1 and 1/0 opacities was one of the most difficult processes of the entire B-reader form. (RX1).

On cross examination, Dr. Meyer testified that it would be possible for a person to appreciate the existence of coal worker's pneumoconiosis by CT that he may have missed or that was not quite as readily apparent on a standard analog chest x-ray. He agreed that it was fair to say that all long-time coal miners were going to come out with some dust deposit trapped in their lungs but that the majority of those would

not have changes in their lungs that qualified for coal worker's pneumoconiosis. He testified that the presence of the coal macule was the pathologic lesion that defined coal worker's pneumoconiosis. (RX1).

On cross examination, Dr. Meyer agreed that the macule of coal worker's pneumoconiosis was a permanent abnormality and that it could progress either by the individual macule becoming larger itself or by more coal dust or mixed dust that is trapped in the lungs causing additional macules or the macules coalescing. He testified that once there was coal worker's pneumoconiosis that was progressing, there was no medicine or anything modern medical science could do to stop or reverse the progression to his knowledge and that removing the worker from the exposure was the best response. (RX1).

On cross examination, Dr. Meyer agreed that coal worker's pneumoconiosis could be considered a chronic progressive disease in some coal miners and that in some coal miners, coal worker's pneumoconiosis can progress even after the miner leaves the exposure. He agreed that if a person has coal worker's pneumoconiosis at any time in their life, it would be true that they probably had the coal worker's pneumoconiosis at some level when they left the coal mine. He agreed that with simple coal worker's pneumoconiosis it could progress to a condition called progressive massive fibrosis, that it could progress to significantly impair pulmonary function and that it could progress to the extent that in involved the heart in a condition called cor pulmonale which, if significant enough, could be life-threatening. (RX1).

On cross examination, Dr. Meyer agreed that generally he would imagine that coal worker's pneumoconiosis would appear first radiographically or pathologically and then later as it became more significant, it would begin to manifest itself in pulmonary function abnormalities or clinical abnormalities. He agreed that the medical term for scarring in the lungs was that of fibrosis. He agreed that when a coal worker has coal worker's pneumoconiosis that progresses, the rate of that progression would vary from miner to miner rather than be exactly the same in all miners. He agreed that the shape, size and location of the macule would also vary from miner to miner. He agreed that some miners might have a slower progressing pneumoconiosis for some number of years and then the pneumoconiosis may begin to progress more rapidly. He testified that he thought that the variation between opacities may be as much variation in B-reading as it was in the actual nodules themselves. (RX1).

On cross examination, Dr. Meyer agreed that coal worker's pneumoconiosis at the level of 1/0 may take 10 years or more to develop and that it could fairly be called a very slow and insidious disease in its onset. He agreed that the miner who has 1/0 pneumoconiosis probably would not know that he has it and probably will not complain to his doctor until he had a B-reading that tells him that he has it. He agreed that histoplasmosis was most likely to occur where the soil had been disturbed, particularly where there had been a lot of bird and bat droppings. He agreed that an operating coal mine was a place where the soil was disturbed. He agreed that when a person has histoplasmosis that was noted on x-ray, there was nothing on the x-ray that told them where the histoplasmosis came from. (RX1).

On cross examination, Dr. Meyer agreed that a macule from coal worker's pneumoconiosis could be the same size as a granuloma and that a macule of coal worker's pneumoconiosis on occasion can become calcified. He testified that histoplasmosis was endemic in the Ohio and Mississippi River valleys and that if you tested the general population, the majority of people had been exposed to histoplasmosis. (RX1).

On cross examination, Dr. Meyer agreed that overexposure of a film would make it more difficult to appreciate the abnormalities of coal worker's pneumoconiosis. He agreed that coal worker's pneumoconiosis was a chronic, slowly progressive disease and not an acute disease which would come on suddenly and have the possibility of resolving. He agreed that coal worker's pneumoconiosis could be a latent and progressive disease and that not all coal miners have a tissue reaction to the dust. He agreed that some were sensitive and had an extreme reaction, but that he also believed that it depended on the composition of the dust itself. He testified that it was his standard when looking at films for B-reading

interpretation to start with the oldest film first and work his way forward so that he did not let the older films bias his early interpretation. (RX1).

On cross examination, Dr. Meyer agreed that the abnormalities of coal worker's pneumoconiosis could be found in the mid and lower lung zone and rarely in the upper lung zones. He agreed that as a B reader, if he saw opacities consistent with pneumoconiosis, he was required to mark them on his B reader form no matter where they were. He testified that there was not any NIOSH or B reader document that he could cite that indicated that coal worker's pneumoconiosis must begin the upper lung zones and could not occur in the middle or lower zones without being in the upper zones. (RX1).

On cross examination, Dr. Meyer agreed that it was possible for a miner to have pneumoconiosis determined by pathology that was not appreciated on a radiographic study. He agreed that it was possible that a miner who had had a split opinion on the existence of pneumoconiosis on radiographs to have pneumoconiosis found at autopsy or biopsy. When asked whether that would prove which of the readers of the radiographic studies was correct, Dr. Meyer responded that it did not and actually just proved that radiology had limitations relative to looking at tissue samples. (RX1).

On cross examination, Dr. Meyer agreed that granulomas can be the same size and shape of opacities of pneumoconiosis but testified that the number was typically much less. He agreed that the abnormalities of pneumoconiosis could be calcified on occasion. He agreed that two qualified and competent B readers could reasonably disagree when a film might be 1/0 or 0/0. (RX1).

On redirect, Dr. Meyer testified that simple pneumoconiosis typically would not progress once exposure ceased. He testified that Petitioner does not have either progressive massive fibrosis or cor pulmonale. He testified that in looking at Petitioner's films, there was no evidence of bulla or hyperinflation. (RX1).

On redirect, Dr. Meyer testified that in looking at his interpretation of Petitioner's films, he did not see any opacities. He testified that for a physician who is not a B reader, an A reader or a radiologist to make a diagnosis of pneumoconiosis, one does not know if he did not say whether it technically met the criteria that the ILO had established for that diagnosis. (RX1).

The transcript of the deposition of Dr. James Castle was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Castle testified that he is a pulmonologist who is board-certified in internal medicine and the subspecialty of pulmonary disease. He testified that he is a B reader and has been certified as a B reader since 1985. (RX2).

Dr. Castle testified that he reviewed a chest x-ray dated September 30, 2014 from Central Illinois Allergy and Respiratory Service, that it was his opinion that there were no parenchymal abnormalities consistent with pneumoconiosis and that there was evidence of what appeared to be plate atelectasis in the left lower zone at the costophrenic angle. He testified that there were no changes of any form of pneumoconiosis including coal worker's pneumoconiosis. He testified that it was his opinion that Petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. He testified that Petitioner did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process, that he did not have the consistent finding of rales, crackles or crepitations and that the vast majority of radiographic reports indicated that there were no findings whatsoever to indicate the presence of coal worker's pneumoconiosis. (RX2).

Dr. Castle testified that the physiologic study obtained at the evaluation of Dr. Paul was a valid study, that the study was entirely normal showing no evidence of obstruction, restriction or diffusion abnormality and that there was no evidence of any respiratory impairment from any cause including coal mine dust exposure or coal worker's pneumoconiosis. He testified that Petitioner does not suffer from any

pulmonary disease or impairment that had occurred as a result of his occupational exposure to coal mine dust. He testified that dyspnea on exertion was a non-specific complaint and could be related to a number of different problems or various organ systems other than the lungs and that it did not necessarily imply a disease state. He testified that his review of the medical records did not support a diagnosis of chronic bronchitis. (RX2).

Dr. Castle testified that based upon the pulmonary function testing performed, the medical records that he reviewed and the films that he reviewed, he believed that Petitioner was capable of heavy manual labor. He testified that he was familiar with the American Medical Association Sixth Edition and that if he were to apply the Guides for the pulmonary system to Petitioner, based upon the testing performed on him the class that Petitioner would fall in was a Class 0. (RX2).

Dr. Castle testified that it was very unlikely for simple pneumoconiosis to progress once the exposure ceased and that it would be a very small percentage of the time. He testified that in his review of the medical records, there was no pathologic evidence of pneumoconiosis in Petitioner. When asked of the clinical significance for someone who had subradiographic pneumoconiosis, Dr. Castle responded that it was really of no clinical significance at all. (RX2).

Dr. Castle testified that Petitioner does not suffer from either cor pulmonale or progressive massive fibrosis and that it would be extraordinarily unlikely for him to develop that in the future. He testified that Petitioner does not suffer from chronic obstructive pulmonary disease. He testified that board certification in pulmonary disease has been present since 1941. (RX2).

On cross examination, Dr. Castle agreed that if one had subradiographic coal worker's pneumoconiosis or coal worker's pneumoconiosis that was picked up on examination of tissue by the microscope, the macules and nodules were of the same constitution of those that might be seen on x-ray. He agreed that if they were in a live coal miner who was still mining coal, they would be subject to a potential progression. (RX2).

On cross examination, Dr. Castle agreed that as to the AMA Guides, pulmonary dysfunction is based strictly on measurable pulmonary dysfunction. He agreed that many people with coal worker's pneumoconiosis or other coal mine-induced lung disease were treated by pulmonologists and other medical specialists for their disease even though they may not be B readers. He testified that the majority of coal worker's pneumoconiosis lesions were going to be the small, round, regular-type of opacities classified as p, q and r, but that certainly coal dust may cause some linear irregular-type opacities but was not the primary type of opacity that was seen. (RX2).

On cross examination, Dr. Castle testified that a coal macule by definition had focal emphysema associated with it. He testified that he read only one film and that the film was quality numeral 1. He testified that if a miner had coal worker's pneumoconiosis, it was more likely to be present prior to leaving the mines rather than developing after he left the mines. He agreed that no matter what he saw on the films, it would not rule out the possibility that Petitioner could have pneumoconiosis that could be found pathologically or on autopsy. He agreed that there were studies that had shown that as many as 50% of long-term coal miners had pathological coal worker's pneumoconiosis that was not appreciated by a radiographic study during their life. (RX2).

On cross examination, Dr. Castle agreed that equally qualified readers who had passed the B reading program could disagree on their interpretation of a chest x-ray. He agreed that all physicians were not as good as all other physicians in taking patient histories and that the same would be true for performing physical examinations of the chest. (RX2).

On cross examination, Dr. Castle agreed that on a regular black lung examination, he would look at the x-ray to determine if an individual had category 1 or early pneumoconiosis, assuming an appropriate exposure history. He agreed that the abnormality of coal worker's pneumoconiosis was basically trapped coal dust in a part of the lung which ended up wrapped in scar tissue and could be accompanied by focal emphysema. He agreed that the affected tissue could not perform the function of normal, healthy lung tissue and therefore if a person has coal worker's pneumoconiosis, they would have an impairment of the function of the lungs at the site of the scarring and emphysema. He testified that if scar tissue was causing a measurable pulmonary impairment, it could be either or both restriction or obstruction. (RX2).

On cross examination, Dr. Castle testified that coal worker's pneumoconiosis was typically insidious in its onset. He agreed that a person can have radiographically significant coal worker's pneumoconiosis and yet have normal spirometry, normal pulmonary function in all areas, normal blood gases, normal physical examination of the chest and maybe even no complaints. He testified that if they did have complaints, shortness of breath was the most likely. He agreed that coal worker's pneumoconiosis could be accurately described as a chronic, slowly progressive disease and that it could progress to a condition called progressive massive fibrosis. He testified that it can progress and involve the heart in a condition called cor pulmonale in people that had very severe disease and have significant functional abnormalities. He agreed that cor pulmonale and progressive massive fibrosis could be life-threatening. (RX2).

On cross examination, Dr. Castle testified that coal worker's pneumoconiosis could progress after cessation of coal mining but that it was very uncommon. He agreed that the macules or nodules could also coalesce causing progression and that if they progressed far enough, it could lead to bullous changes in the lung or large holes in the lung. He testified that there was no way to know before people started coal mining which miner was going to get pneumoconiosis and which ones would not. He testified that for those who got it, there was no way to know which would progress after exposure ended and which would not. He testified that he had heard of people whose pneumoconiosis progressed after they left the coal mine. He agreed that the rate of progression would vary from miner to miner. (RX2).

On cross examination, Dr. Castle agreed that there could be a mixed dust pneumoconiosis from coal mining which would include silica. He agreed that silica was toxic to the surrounding lung tissue and that it was more fibrogenic then coal dust. He testified that if a person had trapped silica in their lungs, it was possible that the toxic effect would be something that was emitted to the surrounding tissue for the rest of their life. He testified that he believed that it was true that the only treatment for coal worker's pneumoconiosis was to remove the miner from any further exposure. (RX2).

On cross examination, Dr. Castle agreed that the scarring of coal worker's pneumoconiosis did not cure and return to normal, healthy lung tissue. He agreed that there was no cure for coal worker's pneumoconiosis. He agreed that pneumoconiosis could show up on pathology prior to showing up on a radiographic study. He agreed that there had been studies that had shown that as much as 50% of long-term coal miners had coal worker's pneumoconiosis that could be determined pathologically at autopsy which was not appreciated radiographically during their life. (RX2).

On cross examination, Dr. Castle agreed that pulmonary function testing, particularly the spirometry, would tell you the type and severity of the abnormality but not its cause. He agreed that coal mine dust-induced lung disease generally begins in the small airways. He agreed that a person could lose an entire lobe of the lung to surgery and yet still have the pulmonary function tests within the range of normal. He agreed that having PFTs within the range of normal did not mean the lungs were free of any lung damage, injury or disease. He agreed that one can have lung cancer with normal PFTs. (RX2).

On cross examination, Dr. Castle agreed that the heart and lungs work together in a system and that chronic lung disease can put an extra burden on the functioning of the heart. He further agreed that chronic

lung disease can put an extra burden on the functioning of the heart through pulmonary hypertension. (RX2).

NIOSH Records were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that chest x-rays of March 11, 1974, February 26, 1988, February 26, 1990, March 23, 1992 and June 21, 2000 were interpreted by A-readers and B-readers as being completely negative. (RX3).

The medical records of Harrisburg Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records reflect that Petitioner underwent a chest x-ray on April 17, 2013, which was interpreted as revealing (1) no active cardiopulmonary disease; (2) bilateral pulmonary hyperinflation; (3) benign chronic changes as described. At the time of the February 5, 2013 visit, Petitioner reported that he was swinging a sledge hammer at work and began experiencing lower back pain. The records reflect that on physical examination Petitioner's breath sounds were clear, that there was no distress present, that there was no wheezing, rales, rhonchi or tachypnea present and that there was normal rate and effort. The records reflect that Petitioner also underwent a chest x-ray on October 11, 1994, which was interpreted as negative. (RX4).

The medical records of Dr. DeGrange were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records reflect that Petitioner was seen by Dr. DeGrange on February 27, 2013 regarding the work injury sustained on February 5, 2013. On that date, it was noted that Petitioner denied constant cough, syncope and shortness of breath. The records reflect that Dr. DeGrange performed surgery on May 20, 2013 (which consisted of (1) L4 laminectomy with decompression of cauda equina and spinal nerve roots; (2) L5 laminectomy with decompression of cauda equina and spinal nerve roots; (3) L4-5 posterolateral spinal fusion; (4) L4-5 posterior pedicle screw instrumentation; (5) use of local autograft, morselized autograft and BMP; (6) insertion of indwelling opioid catheter; (7) use of operating microscope; (8) L4-5 anterior discectomy and interbody fusion; (9) L4-5 anterior lumbar allograft, structural (MTF); (10) L4-5 anterior segmental instrumentation (DePuy/Synthes Antegra) and that he allowed Petitioner to return to limited duty on August 12, 2013. The records further reflect that Dr. DeGrange placed Petitioner at maximum medical improvement on January 13, 2014 and that he was given permanent work restrictions that placed him in a Medium demand capacity, which contemplated that on a constant basis he could lift, carry, push and pull up to 10 pounds, frequently up to 25 pounds and occasionally up to 40 or 50 pounds. (RX5).

The medical records of Mercy Medical were entered into evidence at the time of arbitration as Respondent's Exhibit 6.[1] The records reflect that Petitioner underwent a chest x-ray on May 7, 2013 in preparation for back surgery, the impression of which was noted to be that of no active pulmonary disease. (RX6).

CONCLUSIONS OF LAW

With respect to disputed issue issue (C), pursuant to Section 1(d) of the Workers' Occupational Diseases Act, "the term 'Occupational Disease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public." 820 ILCS 310/1(d). To recover compensation under the Workers' Occupational Diseases Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational exposure need not be

[1] Any handwriting that appears in the exhibit was not made by the Arbitrator.

the sole or principal causative factor, as long as it was a causative factor in the condition of ill-being. *Bernardoni v. Indus. Comm'n*, 362 Ill. App. 3d 582, 596 (3rd Dist. 2005).

In the case at hand, the Arbitrator finds that Petitioner failed to prove that he suffered from any occupational lung disease, including coal workers' pneumoconiosis, that arose out of and in the course of the exposures of his coal mine employment, and that his condition of ill being is causally related to his employment. In so concluding, the Arbitrator finds the chest x-ray interpretations by Drs. Meyer and Castle to be more credible than the interpretations by Drs. Paul, Smith and Alexander. The Arbitrator notes that Dr. Paul is not a B-reader and has never taken the NIOSH B-reading course. (PX1).

The Arbitrator notes that Dr. Meyer found the chest x-ray of September 30, 2014, to be quality 3 due to poor contrast and mottle. (RX1). Dr. Meyer testified that mottle can simulate small opacities, and specifically it can simulate small pinpoint opacities that have an appearance similar to type P opacities. (RX1). Dr. Smith and Dr. Alexander in finding a profusion of 1/0 on the same film considered the possibility that the chest x-ray was negative for pneumoconiosis. Furthermore, Drs. Alexander and Smith noted P opacities and failed to note the presence of mottle, which can simulate P opacities. (PX2; PX3; RX1).

The Arbitrator concludes that Petitioner failed to prove that he suffered a timely disablement as defined in Section 1(e) of the Occupational Diseases Act. Based upon testing performed by Dr. Paul, Petitioner had neither an obstruction or restriction. (PX1). Dr. Paul testified that as of the time of his examination and pulmonary function testing, Petitioner did not have any limitation to doing physical work. (*Id.*). Dr. Castle agreed that Petitioner was capable of heavy manual labor from a pulmonary standpoint. (RX2). No evidence was provided establishing that any doctor restricted Petitioner from working in the coal mines as a result of an occupational disease. Furthermore, there was no evidence in this case that Petitioner left his coal mine employment due to any breathing problems or pulmonary complaints. Petitioner's testimony indicates that he suffered an injury to his back which required surgery. When he was released to return to his regular job as a shield man, Petitioner did not think that he could perform his regular job and opted to take his retirement.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove that he suffered from any occupational lung disease, including coal workers' pneumoconiosis, that his condition of ill-being was causally related to his employment or that he suffered a timely disablement as defined in Section 1(e) of the Occupational Diseases Act. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KARLA MINOR,

Petitioner,

vs. NO: 11 WC 9199

SOUTH MACON FIRE PROTECTION DISTRICT,

Respondent.

18IWCC0542

DECISION AND OPINION ON PETITIONER'S MOTION TO ENFORCE AWARD; MOTION FOR PENALTIES AND FEES; AND MOTION FOR MEDICAL EXPENSES PURSUANT TO SECTION 8(a) OF THE ACT

Procedural History

Petitioner sustained injury on September 10, 2010 when she was struck by an emergency response vehicle. The parties proceeded to arbitration on May 20, 2016 before Arbitrator Nancy Lindsay on the sole issues of 1) entitlement to temporary total disability benefits following March 23, 2012; and 2) the nature and extent of the disability. Arbitrator Lindsay entered her decision on July 21, 2016 finding Petitioner 1) not entitled to temporary total disability benefits after March 23, 2012; and 2) awarding 65% loss of a person as a whole under Section 8(d)2 of the Act. Arbitrator Lindsay also awarded reasonable and necessary medical expenses as set forth in Petitioner's Exhibits 4, 5, and 6. Neither party filed an appeal. As such the decision became final thirty days thereafter. As no appeal was taken, no transcript was prepared.

On September 7, 2017, Petitioner filed her Motion to Enforce Payment of the Award; Petition for Penalties, Interest, Attorney Fees, and Costs; and Petition for Post-Award Medical Expenses pursuant to Section 8(a). On September 7, 2017, Petitioner also filed a Motion to Approve Settlement Agreement and Contract. As part of the civil cause of action arising out of the accident of September 10, 2010, the parties along with Blue Mound Countryside Fire Protection entered into a binding mediation agreement on or about January 30, 2017. As part of

said agreement, Respondent agreed to pay the medical bills previously awarded by Arbitrator Lindsay. The parties subsequently submitted a Settlement Contract Lump Sum Petition and Order which was approved by Commissioner Coppoletti on November 27, 2017. The terms of the settlement resolved all issues exclusive of Petitioner's previously filed Petition for Penalties, Interest, Attorney Fees, and Costs. Regarding Petitioner's Petition for Penalties, Interest, Attorney Fees, and Costs filed on September 7, 2017, Respondent filed its Response on October 2, 2017. On October 4, 2017, a hearing was undertaken before Commissioner Coppoletti in Springfield, Illinois. During the hearing Petitioner withdrew her Petition for Penalties as it related to post-arbitration medical expenses not previously awarded, and Respondent stipulated to payment of said expenses.

Conclusions of Law

At the onset, the Commission notes hundreds of pages of documents were offered into evidence at hearing with detailed spreadsheets from both parties but no specific correlation to the actual medical bills contained in the various exhibits and no supporting medical records. As such the review of the record has been arduous at best. For example, Petitioner's Exhibit 7 purports to be the medical expenses incurred by Petitioner post-arbitration hearing/decision of July 20, 2016. But contained within Exhibit 7 and referenced in the corresponding spreadsheet are various bills and collection notices which date to 2012 and 2015, clearly pre-dating the arbitration hearing. As such, absent the parties' stipulation during the October 4, 2017 hearing, awarding such bills would have been problematic.

A- Post-Arbitration Medical Expenses pursuant to Section 8(a)

As the parties stipulated at hearing to the payment of the medical expenses and the reimbursement to Petitioner as contained in Petitioner's Exhibit 7, the Commission awards medical expenses in the amount of $4,648.50 pursuant to Sections 8 and 8.2 of the Act and payment to Petitioner in the amount of $1,132.92 for reimbursement for previously paid expenses. Respondent is allowed credit for any amounts paid to or on behalf of Petitioner for the expenses identified in Petitioner's Exhibit 7.

B- Petition to Enforce Award

On September 7, 2017, Petitioner filed a Petition to Enforce Payment of the Award along with several other Petitions. Thereafter, the parties agreed to a settlement. Settlement Contracts were submitted and subsequently approved on November 27, 2017 relating to all issues other than Petitioner's Petition for Penalties and Fees. To the extent the Petitioner's Petition to Enforce the Award could be construed to relate to the Settlement Contracts approved on November 27, 2017, the Commission denies the same. The Commission does not possess jurisdiction to enforce a final award whether it be a decision or a settlement contract. See *Millennium Knickerbocker Hotel v. The Illinois Workers' Compensation Commission*, 2017 IL App (1st) 161027WC, ¶ 28 (Thus, to the extent that *Loyola University of Chicago* may be interpreted as implicitly endorsing a procedure whereby a party may seek before the Commission the enforcement of a final award in conjunction with a petition for attorney fees and penalties pursuant to sections 16, 19(k), and 19(l) of the Act, we decline to follow it).

C- Petition for Penalties, Interest, Attorney Fees and Costs

The Appellate Court articulated the standards for the imposition of penalties under the Act two decades ago under *McMahan v. Industrial Commission*:

> Viewing the statue as a whole, we believe that section 19(k) and section 19 (l) were actually intended to address different situations. The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." If the payment is late for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory.
>
> In contrast to section 19(l), section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory. See *Smith v. Industrial Comm'n 170 Ill. App. 3d 626, 632, 121 Ill. Dec. 275, 525 N.E.2d 81 (1988)*. The statute is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statue's use of the terms "vexatious," "intentional" and "merely frivolous." Section 16, which uses identical language, was intended to apply in the same circumstances. *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 515, 702 N.E. 2d 545 (1998).

Regarding penalties pursuant to Section 19(l) of the Act, the Commission finds such penalties appropriate and awards $10,000.00. Respondent has failed to provide an adequate explanation for the delay in payment. Arbitrator Lindsay entered her decision on July 21, 2016 wherein she awarded certain medical expenses. Thereafter, on or about January 30, 2017, the parties entered into a binding mediation agreement wherein Respondent reiterated its commitment to pay the medical expenses previously awarded by Arbitrator Lindsay. As evidenced in Petitioner's Exhibits 5 and 6, some of the previously awarded and agreed to bills remain outstanding. Given the nature of Petitioner's injury, she underwent a significant amount of treatment which resulted in hundreds of thousands of dollars of medical expenses. The Commission observes the vast majority of the expenses were paid by Respondent. Even so, payment of a majority of the medical bills does not excuse Respondent's failure to pay what remains. "The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified." *Jacobo v. Illinois Workers' Compensation Commission*, 2011 IL App (3d) 100807WC, ¶ 19. Respondent's contention that the complexity and vastness of the bills is not reasonable and does not justify the delay.

Regarding penalties pursuant to Section 19(k) and attorneys' fees pursuant to Section 16 of the Act, as noted above, a different standard applies, and such delay in payment must be "deliberate or the result of bad faith or improper purpose." *McMahan* at 515. The Commission finds to award such penalties and fees is not appropriate and declines to award the same. Respondent's failure to pay the outstanding bills was neglectful and without good and just cause; it was not intentional nor done in bad faith nor with improper purpose. Petitioner posits because

she was forced to file multiple Petitions pursuant to Sections 19(k) & (l) and Section 16 throughout the pendency of this matter, such evidences conduct by Respondent amounting to vexatiousness or intentionality. The Commission, though, finds the opposite. Petitioner did not proceed to hearing on any of her prior Petitions for Penalties and Fees despite referring to such as orders during argument. Respondent presumably issued payment for the bills and, in fact, paid a voluntary penalty of $40,000.00. Such conduct on Respondent's behalf evidences negligence and a lack of competence but not a deliberate and intentional refusal. Petitioner conceded at hearing that the new claims adjustor assigned to the matter is, in fact, paying the bills in a more diligent manner. Penalties pursuant to Section 19(k) and attorneys' fees pursuant to Section 16 of the Act are not warranted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties, Interest, Attorney Fees, and Costs is granted in part and denied in part.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $10,000.00 pursuant to Section 19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses in the amount of $4,648.50 pursuant to Sections 8 and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $1,132.92 for reimbursement of previously paid medical 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.

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: SEP 5 - 2018

L. Elizabeth Coppoletti

LEC
r100417
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L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

Thomas Johnson,

Petitioner,

vs. NO: 12WC 15918

City of Chicago, Department of Water,

18IWCC0543

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, temporary total disability, 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 November 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.

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: SEP 5 - 2018
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MJB/jrc
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Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

JOHNSON, THOMAS
Employee/Petitioner

Case# **12WC015918**

10WC003399

CITY OF CHICAGO DEPT OF WATER
Employer/Respondent

18IWCC0543

On 11/21/2017, 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 1.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5669 ALEKSY BELCHER
RICHARD E ALEKSY
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0010 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

18IWCC0543

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)

Thomas Johnson
Employee/Petitioner

v.

City of Chicago, Dept. of Water
Employer/Respondent

Case # 12 WC 15918

Consolidated cases: 10 WC 03399

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 **5/23/17**. 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. [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. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **May 3, 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 **$93,808.00**; the average weekly wage was **$1,804.00**.

On the date of accident, Petitioner was **56** 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 is entitled to a credit of **$67,524.70** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$203,200.00** for other benefits, for a total credit of **$270,724.70**. (AX 1)

Respondent is entitled to a credit of **$5,190.90** under Section 8(j) of the Act. (AX 1)

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,202.67**/week for **263-5/7** weeks, commencing on **5/4/2012** through **5/23/2017**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit **$67,524.70** for TTD benefits paid, **$186,582.00** for ordinary disability paid, and **$16,618.00** for a PPD advance made.

Respondent shall be given a credit of **$5,190.90** under Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services of **$279,000.34**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay for the prospective medical care as determined by the Arbitrator on page 62 of Attachment.

Respondent shall pay to Petitioner penalties of **$6,870.00**, as provided in Section 19(l) of the Act, and **$0.00**, as provided in Section 19(k) of the Act, and shall pay attorneys' fees of **$0.00**, 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 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

11/20/2017
Date

NOV 21 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ATTACHMENT TO 19(b) ARBITRATION DECISION

Thomas Johnson

vs. Case # 12 WC 05918

City of Chicago, Department of Water

FINDINGS OF FACT

On May 3, 2012, Petitioner, Thomas Johnson, aged 56, was working as a hoisting engineer and heavy equipment operator for the City of Chicago's Department of Water. Petitioner had been employed by the City of Chicago for over 16 years on that date. (Tr. 8-10)

Prior to May 2012, Petitioner had undergone treatment for a prior workers' compensation case involving an injury to his back. His treating physicians had never released him to full-duty work after that initial injury and Petitioner remained under doctor's restrictions as of May 3, 2012, the date of the subsequent injury. Respondent never accommodated Petitioner's restrictions from the prior injury upon his return to work. (Tr. 9-10)

Petitioner testified that on May 3, 2012, as he was exiting the Vactor machine, he slipped on water and hydraulic fluid on a step on the machine. He testified that he "went to get the bottom step," but he "didn't really hit it." When he tried to catch himself, he felt a big pop in his back, saw spots, twisted, and fell to the ground on his right side. He further testified that he tried to break the fall with his right hand and that he "kind of popped [his] hand back and landed on [his] elbow and [his] hip." (Tr. 12-13)

Petitioner testified that he gave notice of the injury to Marsha. (Tr. 13-14)

Petitioner prepared a "Report of Occupational Injury or Illness," which he signed and dated. (RX 7) Engineer Foreman Marsha Simmons also signed and dated the form. In it, Petitioner provided the following description of the injury:

"Stepped on bottom step with right foot. Sharp pain – leg gave out.
Saw spots, Hip feels extremely sore with back. Fell (sprawled).
Got up." (RX 7)

On cross-examination, Petitioner gave the following responses:

Q: Now, you testified, though, that you missed the bottom step.

A: Yes.

Q: That [Report of Occupational Injury or Illness] says that you actually stepped on the bottom step, correct?

A: My foot hit the bottom step, but I was never really able to - - You know it happened pretty fast. I stepped off the top step. When I slipped, my back went out, and I tried to hit the other step. I just went sprawling.

Q: But there's a difference between missing a bottom step and stepping on a bottom step.

A: Yes.

Q: Okay. This also says that your leg gave out, your right leg gave out.

A: Yes.

Q: Okay. You didn't mention that today.

A: Well, I got a sharp pain in my back.

Q: Okay.

A: And I slipped, and then my right foot, I couldn't step on my right foot.

(Tr. 79-80, Words in Brackets Added)

Petitioner testified that after he reported the injury, Marsha told him to see Dr. Pye at the MercyWorks clinic at 110th and Western. Petitioner proceeded to this clinic that same day, but when he arrived, he was directed to the MercyWorks clinic at 23rd and Michigan for drug testing. (Tr. 13-14)

Petitioner thereafter took a drug test and underwent a brief physical examination at the latter MercyWorks clinic. The attending doctor, Dr. J. S. Bartolome, wrote: "The patient states that while stepping out of the truck with his right leg, his leg gave out, causing him to fall on the right side of his body. Pain scale was noted at 7/10." Dr. Bartolome noted a previous left hip replacement surgery. Dr. Bartolome ordered x-rays of the right elbow, lumbar spine, and right hip,and provided diagnoses of right elbow abrasion, lumbar strain, and right hip strain. Petitioner was taken off work and directed back to Dr. Pye's office for treatment. (PX 1)

X-rays were performed at MercyWorks the following day, May 4, 2012. (PX 2)

Petitioner's Exhibit #2 indicates that Petitioner first saw Dr. Pye on May 7, 2012. In the HPI, Dr. Pye included the following: "STATES REAGGRAVATED BACK INJURY WHEN

ATTEMPTING TO STEP OFF TRUCK. AS HE WAS COMING OFF TRUCK FELT SHARP SHOOTING PAIN. THIS PAIN CAUSED HIM TO FALL OFF TRUCK. UNAWARE OF EXACT MECHANISM OF AS (sic) HE WAS COKING (sic) OFF TRUCK LANDED ON GROUND ON RIGHT SIDE. (PX 2) At that time, Petitioner complained to the doctor of back pain, right hip pain, right groin pain, right elbow pain, right wrist pain, right shoulder pain, and right knee pain. Upon examining Petitioner, Dr. Pye found, in pertinent part, the following:

> "THORACOLUMBAR: POS TENDERNESS FROM T2 TO L5 MORE ON RT THAN LFT. MULTIPLE AREAS OF TRIGGER POINT OVER THORACIC AND LS. AROM LS: FF AT WAIS TO 40 DEG WITH DISCOMFORT. EX-TEN AT WAIS 30 DEG WITH DISC. ANTALGIC GAIT AND STATION. MOTOR SENSORY OF LE: GROSSLY INTACT.
>
> RT HAND: NORMAL, NEG. ABRASIONS, NO CREPITUS OR DEFORMITY NOTED. INSPECTION OF WRIST WAS NORMAL. AROM: NORMAL. NORMAL FOR DF, PF, RD, AND UD. FULL ROM OF ALL DIGITS W/O PAIN. HAD MILD TENDER IN ANATOMIC SNUFF BOX. ***
>
> RT KNEE: POST LATERAL JOINT LINE TEND. POST TENDER OVER PROXIMAL FIBULAR HEAD. POS TENDERNESS OVER HAMSTRING TENDONS. POS TENDERNESS OVER COLLATERAL LIGAMENTS. NEG SWELLING WAS NOTED. POS TEND OVER PATELLAR TO PALPATIO (sic) AROM 1-140. NEG LACHMAN, NEG PIVOT, NEG APLEY NEG McMURRAY, POSITIVE PATERLLAR (sic) COMPRESSION TEST
>
> RT FOREARM: POS TENDERNESS OVER PROXIMARL (sic) RIG FOREARM. NEG SWELLING, DEFORMITY OR ABRASIONS NOTED.
>
> RT HIP: POS TEND OVER RT GREATER TROCHANTER. POST TEND IN RT GROIN TO PALPALTION (sic) FULL FLEXION W/ DISCOMFORT AND FULL EXTENS. NORMAL IR AND ER."

Dr. Pye prescribed a course of physical therapy, as well as Tramadol, Celebrex, and

Nexium. Dr. Pye opined that Petitioner could return to work with significant restrictions, which included no pushing, pulling, lifting, or carrying more than 2 lbs. (PX 2)

When the Petitioner took the work status note to the District Superintendent, he learned that Respondent could not accommodate his restrictions. He thereafter took the note to another facility in order to obtain authorization for temporary total disability benefits. (Tr. 16-17)

During the course of the initial treatment with Dr. Pye, Petitioner was directed to get additional x-rays of his elbow, right hip and right wrist, along with an MRI of his lumbar spine. (PX 2)

On May 9, 2012, Petitioner began treating at U.S. Rehabilitation Services. The facility for U.S Rehabilitation Services was in the same building as Dr. Pye's group. (Tr. 18) Physical Therapist Ellen O'Donnell conducted the initial evaluation of Petitioner. Ms. O'Donnell recorded the following history:

> "DOI – 5-3-12 – Pt was at work, was stepping down some steps, with R foot, slipped, felt a sharp pain in RLB which made his leg give out, he twisted, fell and hit his R elbow and wrist and landed on his R hip. Tried to get up and he was having a hard time putting wt on R foot. Went to mercyworks Dr. that day .... Came back to Dr. PYe for snd visit (sic)." (PX 3)

At the direction of Dr. Pye, Petitioner returned for follow-up treatment with him throughout the balance of May 2012. The appointments with Dr. Pye were interspersed with

additional physical therapy visits. Though Petitioner continued to complain of pain to his lower back and right hip, Dr. Pye continued his approach of conservative pain management by continuing to recommend massage therapy and other modalities, as provided by U.S. Rehabilitation Services. (PX 2, PX 3)

On May 30, 2012, Ellen O'Donnell, PT, wrote: "There still may be something in his R hip which is causing the pain and couldn't be identified by x-ray." (PX 3)

Petitioner returned to Dr. Pye's office for follow-up treatment on June 5, 2012. Dr. Pye noted the following surgical history: left hip replacement, right thumb, right knee, right shoulder, and left shoulder. On physical examination, Petitioner demonstrated significant muscle spasm, limited range of motion, an inability to heel and toe walk, chronic pain in the groin region, as well as limited hip range of motion secondary to pain. Dr. Pye prescribed continuing physical therapy, pain medication on an "as needed" basis, and acupuncture. The doctor also issued another work status note that indicated Petitioner could return to work with several restrictions. (PX 2)

On June 6, 2012, Ellen O'Donnell, PT, noted that Petitioner voiced no complaints of right wrist or elbow pain. Petitioner continued with physical therapy throughout the month of June. (PX 3)

Petitioner testified on redirect examination that as a result of landing on his right hip, he developed a bruise on this hip. (Tr. 90)

On June 18, 2012, upon examination, Dr. Pye found, *inter alia*, that Petitioner had a 3 x 4 centimeter area of induration and ecchymosis on the proximal lateral aspect of right hip and

positive tenderness to palpation of greater trochanter. Dr. Pye opined that Petitioner could perform sedentary work only and needed to continue with physical therapy. The doctor then referred the Petitioner to Dr. Neeraj Jain for pain management and a possible epidural steroid injection into the spine. (PX 2)

On July 9, 2012, Dr. Pye saw Petitioner again, and took the following HPI:

"Today he states pain in back is 5/10. Pain is present all day. Pain is also associated w/sharp shooting and burning pain that radiates into rt. buttock down the posterior aspect of rt. thigh and stops at knee. Pain is present with all adls. He states that his rt. hip and groin pain is also 5/10 and is also present w/prolonged walking, standing, and stairclimbing. The groin pain that is present in the rt. hip feels like the pain he had in lt. hip before he had surgery in lt. hip as a result of injury that caused avn of the femoral head. He states pain in right wrist is increased w/push, pull, and lifting of objects that weigh more than 10 lbs. Pain in rt. wrist is also 5/10 and does not appear to improve w/rest or meds. He states sharp, shooting pain in low back that radiates in buttock keeps him up at night and interferes w/much of his activities of daily living." (PX 2)

Dr. Pye recommended x-rays and MRI of the right hip and lumbar spine, as well as additional x-rays of the neck and right wrist. The doctor recommended that Petitioner undergo a functional capacity evaluation ("FCE"), and provided referrals to Dr. Charles Slack for a spine

evaluation and to specialist Martin Moore for acupuncture treatment. Dr. Pye further directed Petitioner to continue with his prescribed physical therapy. (PX 2)

At the direction of Dr. Pye, x-rays of Petitioner's right hip, cervical spine, and right wrist were taken on July 16, 2012 at Advanced Medical Center. The c-spine x-rays were found to be unremarkable, the right hip x-rays revealed mild degenerative changes, but were otherwise unremarkable. Right wrist and hand x-rays were found to be unremarkable, and no gross soft tissue abnormalities were seen. In an addendum, the radiologist interpreted a third view of the hand as showing a "deformity at the base of the distal phalanx of the index finger which may be secondary to prior injury." (PX 2)

Petitioner thereafter returned to see Dr. Pye on July 20, 2012, at which time he again complained of increased pain in the hip and groin, as well as lumbar pain and pain in the right wrist and hand. Petitioner's rating of his right hip pain increased to 6/10. Dr. Pye wrote that an MRI was reviewed with the patient and it revealed the presence of AVN in the right hip. Dr. Pye provided the following ASSESSMENTS: 1. Aseptic necrosis of head and neck of femur; 2. Sciatica; 3. Lumbar sprain and strain; 4. Unspecified site of sprain and strain. Dr. Pye directed Petitioner to remain on his current restrictions and continue with physical therapy. The doctor referred Petitioner to Dr. Shayani for an EMG/NCS. (PX 2)

Petitioner continued to follow the directions of Dr. Pye by attending additional physical therapy and continuing with his prescribed medication. On August 3, 2012, Dr. Pye referred Petitioner to a Dr. David Smith for treatment of his persistent right hip pain. (PX 2)

Petitioner first treated with Dr. Smith on August 13, 2012. At this initial visit, Dr. Smith

reviewed the x-rays of Petitioner's right wrist and hand, as well as the MRI report of the right hip. Dr. Smith opined that the MRI results were compatible with osteonecrosis of the hip. The doctor recommended an MR arthrogram and CT scan with 3D reconstruction of the right hip, and instructed Petitioner to stay off work and return after the tests had been completed. (PX 6)

Petitioner testified that Respondent's policy was that an injured employee was required to return for follow up with Dr. Pye after each of his visits to a referred doctor. Thus, a week after his initial visit with Dr. Smith, on August 20, 2012, Petitioner once again returned to see Dr. Pye for follow-up care. Dr. Pye's notes indicate that Dr. Smith believed Petitioner to be a candidate for a right total hip replacement, that physical therapy had not been approved, and that acupuncture treatment had never commenced. Dr. Pye wrote that he would request authorization for PT as well as three to four acupuncture treatments, custom orthotics, and a lumbar brace. The doctor instructed Petitioner to start Lyrica and advised him that he could return to work with restrictions. (PX 2)

Per Dr. Pye's referral, Petitioner presented himself to Dr. Charles Slack on August 22, 2012. Dr. Slack documented Petitioner's continuing complaints of pain, as well as the sequence of events that led to his injury. Petitioner advised the doctor that he had seen Dr. Smith and was scheduled to receive a MRI of the right hip. Dr. Slack performed a physical examination of Petitioner and thereafter provided the diagnosis of persistent low back derangement with radicular symptoms. The doctor instructed Petitioner to return for a review of the MRI results and directed him to follow up with Dr. Smith for further treatment for his hip. (PX 4)

As Respondent's protocol dictated, Petitioner returned to Dr. Pye for a follow-up

appointment on August 28, 2012, at which time the doctor instructed him to again see Dr. Jain for pain management. (PX 2)

Petitioner once again saw Dr. Pye on September 4, 2012, at which time the doctor directed him to continue with any testing that Dr. Smith and Dr. Slack recommended. Dr. Pye noted that Respondent was not providing an accommodation for Petitioner's restricted work capabilities. (PX 2)

On September 5, 2012, Petitioner underwent an MRI and CT scan of his lower extremities at Ingalls Memorial Hospital. The MRI revealed avascular necrosis ("new from 2009") of the right femoral head without any evidence of articular collapse, as well as a tear of the superior, anterior labrum that was associated with 2.1 x .8 x 1.5 centimeter multilocular cystic lesion. The MRI also demonstrated a high T2 signal within the hamstring origin measuring .3 x .5 centimeters, which might represent a strain or partial tearing. The subsequently-taken CT scan without contrast showed evidence of avascular necrosis involving approximately one-third of the femoral head. There were secondary mild degenerative changes of the right femoral acetabular joint, but no collapse of the femoral head. (PX 7, PX 4)

As directed by Dr. Pye, Petitioner underwent an FCE on September 6, 2012. The evaluation demonstrated that though Petitioner was capable of operating at the medium physical demand level, he remained unable to perform at the heavy demand level, which correlated with his position with Respondent. (PX 3)

Petitioner thereafter returned to Dr. Pye for follow-up on September 20, 2012. Dr. Pye determined that Petitioner should continue with his medication, physical therapy, and

acupuncture. The doctor further instructed Petitioner to remain off work and to follow up with both Dr. Smith and Dr. Slack. (PX 2)

Petitioner returned to the care of Dr. Smith on September 28, 2012. Dr. Smith essentially agreed with Dr. Pye's opinion that Petitioner should remain off work. Upon review of the results from the MR arthrogram, Dr. Smith directed Petitioner to modify his activities and to monitor his progression. (PX 6)

As required by Respondent, Petitioner then returned to see Dr. Pye on October 3, 2012 for follow-up. Dr. Pye once again noted that Petitioner continued to await approval for continued physical therapy. The doctor instructed Petitioner to follow up with Dr. Slack. (PX 2)

Petitioner testified that, at this appointment, Dr. Pye had also discussed acupuncture and chiropractic care with him. To that end, the doctor suggested that Petitioner see Dr. Mehran Sorouri to obtain this treatment. (PX 2)

Petitioner underwent chiropractic care with Dr. Sorouri for several weeks in October 2012. (PX 8) At Petitioner's follow-up appointment with Dr. Pye on October 25, 2012, the doctor instructed him to continue taking the prescribed medication, to return to his course of physical therapy when the treatment was authorized, and to obtain acupuncture treatment for relief of his lower back pain. Dr. Pye kept Petitioner off work and instructed him to return to see Dr. Slack and Dr. Smith. (PX 2)

Dr. Slack authored a note relative to his treatment of Petitioner on November 8, 2012. Petitioner continued to report pain in his right lower back and buttocks, as well as in his posterior thigh when attempting to perform exercises during physical therapy. The doctor indicated that

he would like to review the MRI CD to determine whether the spine was stable; if confirmed, Dr. Slack noted that he would consider proceeding with an FCE. Dr. Slack released Petitioner to return to work with restrictions that included a 10-lb. lifting restriction, as well as the avoidance of repetitive bending, twisting, and lifting. (PX 4)

On November 28, 2012, Petitioner returned to Dr. Pye for his required follow up and complained of continued pain in his lower back and hip. Dr. Pye indicated in his notes that Dr. Slack was actively considering prescribing a rhizotomy for the treatment of Petitioner's lower back condition. Dr. Pye instructed Petitioner to continue treatment with both Dr. Smith and Dr. Slack. (PX 2)

Petitioner's treatment with Dr. Smith continued periodically between December 2012 and April of 2013. On February 20, 2013, Dr. Smith documented that Petitioner continued to demonstrate a positive Faber's test, positive flexion and internal rotation, positive start-up pain, and an antalgic gait. The doctor directed Petitioner to remain off work and discussed the possibility that he might have to undergo hip surgery. (PX 6)

Petitioner testified that he became disgruntled with the Dr. Smith's "wishy-washy" recommendations. Dr. Smith initially recommended a right total hip replacement, and later opined that Petitioner might be able to put it off for a couple of years. (Tr. 87-88)

Petitioner eventually decided to seek out a second opinion with regard to his right hip condition. Before Petitioner was able to do so, however, Respondent directed him to present to Dr. Jay Levin for a Section 12 examination.

On April 17, 2013, Dr. Levin performed the Section 12 exam of Petitioner. The doctor

recorded that Petitioner states that prior to the occurrence of May 3, 2012, he was having no hip pain prior to the accident, but was having low back pain and right buttock pain with right foot numbness with prolonged standing. Dr. Levin also recorded that Petitioner states that on May 3, 2012, he was getting out of a Vactor machine and was approximately 5' up when he stepped out onto the 2nd step, which put him 3' up with his right leg. He states these were vertical steps and that his right leg collapsed and he fell forward and sideways striking his right arm and elbow and right buttock and right hip on the concrete. He states he had instant right hip pain and low back pain. Dr. Levin examined Petitioner and reviewed the medical records. However, before he rendered any opinions, Dr. Levin requested the post-accident MRI, MR arthrogram, and x-rays of Petitioner's right hip. (RX 3, Dep. Group Ex. 2)

In a report dated May 10, 2013, after he reviewed the imaging studies and additional records, Dr. Levin offered his opinions. Dr. Levin diagnosed Petitioner with non-traumatic right hip avascular necrosis with corresponding changes in the right hip acetabulum consistent with degenerative changes. Dr. Levin stated that there "does not appear to be any acute changes in the MRI of the examinee's hip that was obtained on July 16, 2012 to suggest that this underlying pre-existing avascular necrosis, which became symptomatic on May 3, 2012, without any acute component to it from the fall (sic)." Dr. Levin confirmed that further treatment was necessary for this hip condition and indicated that a total right hip arthroplasty was required. Due to Petitioner's ongoing hip condition, Dr. Levin determined that he could not work at a heavy physical demand level and that he was instead only able to return to work at a sedentary or light physical demand position. (RX 3, Dep. Group Ex. 2)

On June 12, 2013, Dr. Smith authored a work status note that indicated Petitioner should remain off work. The doctor placed Petitioner on a 25-lb. lifting restriction and directed him to avoid repetitive bending and twisting activities. (PX 6)

Consistent with Respondent's policy, Petitioner then saw Dr. Pye the following day in order to update the doctor on the progress of his treatment and to deliver the work status note that Dr. Smith authored the previous day. (PX 2)

Though Respondent paid Petitioner temporary total disability benefits commencing the day after his accidental injury of May 3, 2012, Petitioner testified that they stopped paying these benefits in 2013. (Tr. 36, AX 1)

Arbitrator's Exhibit 1 indicates that Respondent paid TTD benefits from "5/4/12 – 5/31/13." (AX 1) Petitioner testified that he stopped receiving TTD benefits and was instructed to apply for ordinary disability, which he did. (Tr. 36-37)

On July 8, 2013, Petitioner returned to Dr. Slack. He provided the doctor with an update regarding Dr. Smith's continued treatment of his hip condition and advised him of Dr. Levin's recent Section 12 exam. Petitioner complained of lower back pain with stabbing sensations, and he advised the doctor that his pain was exacerbated when entering and exiting his vehicle, ambulating stairs, and after sitting or standing for any length of time. On physical examination, Petitioner demonstrated a slow and deliberate gait pattern on ambulation and right-sided low back pain upon toe and heel stand. A forward flexion test to 60 degrees and a right-sided rotation test both caused Petitioner right-sided lower back pain, and a supine straight leg raise at 50 degrees caused Petitioner right-sided lower back pain, buttocks pain, and posterior thigh pain.

Dr. Slack determined that Petitioner should proceed with diagnostic facet blocks in order to localize his pain response and to provide him with temporary relief of his pain; if the blocks proved successful, Dr. Slack determined, Petitioner would be a candidate for a radiofrequency lesioning procedure. The doctor provided another work status note that indicated Petitioner's ability to return to work with several restrictions, and recommended an additional FCE in order to obtain further information regarding Petitioner's physical abilities. (PX 4)

As required by Respondent, Petitioner thereafter returned to Dr. Pye's office on July 11, 2013 for follow-up instructions. Petitioner advised the doctor that since being cut off by Respondent on July 1, 2013, he was now being forced to use his own personal health insurance to pay for his ongoing treatment. Dr. Pye instructed Petitioner to continue with his medications, physical therapy, acupuncture, and massage, and kept him off work since Respondent was unable to offer an accommodated position. (PX 2)

On July 22, 2013, Ellen O'Donnell, PT, noted that Petitioner woke up with some pain in the right thoracic area for an unknown reason. (PX 3)

Dr. Pye referred Petitioner to yet another pain specialist, Dr. Ernesto Padron, of Park Ridge Pain Specialists, on July 25. 2013. Dr. Pye also prescribed a Medrol Dose Pak and maintained Petitioner's work restrictions. Petitioner continued to see Dr. Pye either directly or in response to Respondent's policy of seeing him after he saw other physicians to whom Dr. Pye referred Petitioner. (PX 2)

Dr. Pye maintained Petitioner's work restrictions throughout the months of August, September, October, November, and December of 2013. (PX 2)

Respondent requested that Petitioner present himself to Dr. Daniel Troy for a Section 12 examination. Dr. Troy performed this examination on January 16, 2014. He also reviewed the medical records and diagnostic test results. The doctor found that Petitioner's main complaints of pain are to the hip area, which led to secondary low back complaints. Dr. Troy diagnosed Petitioner with avascular necrosis of the right hip, which is not work-related. He thought that Petitioner could entertain intervention to the right hip consistent with core reaming or possibly a free fibular graft. He also thought that Petitioner could possibly pursue more aggressive treatment such as a right total hip replacement. As for the lower back, Dr. Troy thought Petitioner should continue with a home program of therapy or possibly facet injections and medial branch blocks. Dr. Troy found that in May 2012, Petitioner reached MMI for his work injury. (RX 4, Dep. Ex. 2)

Approximately two weeks after Dr. Troy's examination, on January 31, 2014, Petitioner underwent treatment for facet arthroplasty, low back pain syndrome, and spondylosis of the lumbar spine. This treatment, which had been recommended by both Dr. Slack and Dr. Pye, consisted of medial branch posterior rami blocks at the levels of L2-3, L3-4, L4-5 and L5-S1 under fluoroscopic guidance. Dr. Milorad Cupic administered the blocks. (PX 9)

Petitioner thereafter saw Dr. Smith for post-surgery follow up on February 14, 2014. (PX 6)

Petitioner returned to Dr. Cupic on February 19, 2014 for surgical intervention. On this date, Dr. Cupic performed an ablation of the middle branch of the posterior rami at the levels of L2-3, L3-4, L4-5 and L5-S1 on the right side under fluoroscopy. (PX 9)

About a week after this second intervention to the lumbar spine, on February 27, 2014, Petitioner returned to Dr. Slack's office to report on the results of Dr. Cupic's intervention. Dr. Slack noted that Petitioner experienced some improvement with regard to his right leg pain and lower back pain, though he did still suffer pain while rising from a seated position. Dr. Slack provided the diagnosis of persistent low back derangement with painful lumbar facet spondylosis due to symptomatic aggravation. The doctor issued another work status note, in which he again indicated Petitioner could only return to work with restrictions that consisted of 25-lbs. lifting, avoidance of prolonged standing, sitting, or repetitive bending and twisting, and the allowance to change positions as necessary. Petitioner saw Dr. Slack approximately once a month for the remainder of the year. Dr. Slack continued to impose work restrictions on Petitioner. (PX 4)

Petitioner also continued treatment with Dr. David Smith. Both Dr. Slack and Dr. Smith continued to make treatment recommendations for Petitioner. (PX 6, PX 4)

Petitioner testified that as of July 1, 2013, Respondent no longer authorized Petitioner to treat with these doctors. At some point, Petitioner testified, he discovered that his health insurance had lapsed in 2013, and that there was a mix-up about the payments he had sent. (Tr. 34-35) On cross-examination, Petitioner denied that his insurance was stopped with Respondent because he was not paying the premiums. (Tr. 76)

On March 13, 2015, on a referral from Dr. Slack, hand surgeon Michael Jablon, M.D., examined Petitioner. (PX 4) With regard to the HPI and current complaints, Dr. Jablon wrote the following:

"He is a 59-year-old hoisting engineer who presents for evaluation of her (sic) right hand, thumb and wrist injury. He noted that on May 4, 2012, he fell at work when twisting out of a machine and his right thumb "popped out of place" and he has had significant pain at the base of his thumb with disuse subsequently. *** Intake information includes he is right hand dominant." (PX 4)

Dr. Jablon then performed a physical examination and ordered x-rays of the right hand. He noted that the x-rays demonstrated CMC trapeziometacarpal joint osteoarthritis with deep formation at the base of the right metacarpal with small ossicle present. Dr. Jablon's treatment plan included ligament reconstruction and tendon interposition arthroplasty. The doctor also administered a cortisone injection to Petitioner's right thumb in order to address the trapeziometacarpal pain that he suffered therein. (PX 4)

On March 30, 2015, Petitioner returned to Dr. Slack's office for further treatment. He complained of ongoing right lower back pain and diminished functioning. Dr. Slack determined that an MRI of the lumbar spine would be necessary. (PX 4)

Petitioner returned to Dr. Jablon for follow-up treatment on April 24, 2015. Dr. Jablon concluded that Petitioner was not yet ready for any sort of surgical intervention as he had experienced some benefit from the previously administered Cortisone injection. The doctor recommended the use of a push splint for heavy-duty activities, a trial application of Voltaren gel, and further monitoring. Dr. Jablon instructed Petitioner to return for follow-up treatment in a few months. (PX 4)

Dr. Slack's request for an MRI was honored on April 30, 2015. On that date, at Southwest Hospital, MR images of Petitioner's lumbar spine were taken. Dr. Gregory Ostrowski's findings included a rudimentary disc at S1-2, and subtle posterior bulging disc at L4-5. His impression of the images is as follows: "Mild spondylitic changes, unchanged since 3-1-04 exam. No acute appearing abnormalities to account for patient's symptoms." (PX 4)

Dr. Slack thereafter reviewed the results of the lumbar spine MRI on August 6, 2015. The doctor provided the diagnosis of degenerative lumbar disc and facet disease with persistent symptomatic aggravation. He instructed Petitioner to remain as active as possible via an exercise program and ordered him to return to his office within eight weeks. (PX 4)

Petitioner testified that Dr. Slack referred him to Dr. Benjamin Domb for a second opinion. Petitioner also testified that his lawyer mentioned a handful of surgeons, which included Dr. Domb. Petitioner testified that of more than a few people that had been recommended, Dr. Domb "seemed to be the consensus of a really good doctor." (Tr. 86)

Petitioner first presented to Dr. Domb on October 29, 2015. Dr. Domb wrote: "This is a very pleasant 60-year-old male referred to our office by his attorney. Dr. Domb took a history in which Petitioner stated he had a history of low back and right hip pain beginning in 2009 following a work-related injury with Respondent. Dr. Domb also wrote that Petitioner's back pain was more distracting than his hip pain and that he has gone through an extensive treatment regimen for his back. His hip pain has persisted following the initial 2009 injury as well, and he was diagnosed in 2012 with AVN by Dr. David Smith based on MRI results. Dr. Domb conducted a physical examination of Petitioner's right hip. He took x-rays of Petitioner, which

revealed a Grade 1 femoral head consistent with AVN, as well as a large CAM morphology. The doctor assessed Petitioner with ongoing right hip pain in the setting of Stage I or Stage II AVN on plain radiographs. "Unfortunately," Dr. Domb wrote, Petitioner "has forgotten his previous MRI" and "we would like to obtain these to confirm our suspicion of AVN." Dr. Domb then opined that it is with medical certainty that Petitioner's current hip symptoms are directly correlated with his 2009 work injury. (PX 10)

On November 5, 2015, Dr. Domb reviewed the MRI of the right hip that was taken on September 5, 2012. Dr. Domb wrote that such MRI confirmed avascular necrosis of the femoral head. He recommended that Petitioner undergo a minimally invasive total hip replacement. (PX 10)

Petitioner returned to see Dr. Domb on November 23, 2015. Dr. Domb recorded the following HISTORY OF PRESENT ILLNESS:

> "The patient states that back in 2009, he injured his back in a work-related injury. He states then in 2012, he had another injury which involved his back and his right hip. He states that he was getting out of a machine, he was having recurrent back pain. He stepped on a wet step of the machine and slipped. He states he had immediate onset of severe back pain which he has had in the past; over the past years. When he has a moment like this the pain is quite severe. He sees "stars." He states the pain was so severe that he twisted on the wet step, falling and landing on his right hip. He had

to have someone help him to get up off the ground. He has never had any prior right hip pain before this injury in 2012. On the pain now is anterior groin and severe (sic), especially with walking, bending, any kind of activity." (PX 10)

After examining Petitioner, Dr. Domb offered the following IMPRESSION:

"Right hip avascular necrosis of the femoral head. The patient was asymptomatic prior to his 2009 back injury. Symptoms began after the 2012 hip injury."

Petitioner continued to follow-up with Dr. Benjamin Domb and Dr. Charles Slack throughout October and November of 2015. Petitioner eventually determined that he would proceed with the hip surgery recommended by Dr. Domb, and he thereafter underwent pre-op testing with PCP John Elsen and at Little Company of Mary Hospital. (PX 5, PX 11) At his follow-up appointment with Dr. Domb on February 23, 2016, Dr. Domb and Petitioner together determined that the hip replacement surgery was the only satisfactory way to resolve Petitioner's hip condition. (PX 10)

In addition to his continued treatment with both Dr. Domb and Dr. Slack, Petitioner also saw Dr. Mark Gonzalez, the doctor who had replaced Dr. Jablon as the main treating physician for his hand and wrist problems after Dr. Jablon retired. Petitioner's first treatment with Dr. Gonzalez took place on March 1, 2016. Dr. Gonzalez agreed with Dr. Jablon's recommendation that Petitioner undergo ligament reconstruction and tendon interposition. (PX 4)

On March 14, 2016, Dr. Gonzalez provided a pre-op diagnosis of right thumb stage IV

carpometacarpal joint arthritis. The doctor then performed a ligament reconstruction, a tendon interposition, and a right thumb carpometacarpal joint with trapeziectomy. (PX 12) After his surgery, Petitioner continued to see Dr. Gonzalez approximately each week for the remainder of March and into April. On May 10, 2016, Dr. Gonzalez determined that Petitioner required physical therapy treatment to improve the range of motion of his right hand. The doctor instructed Petitioner to return in a few weeks for a re-evaluation. (PX 4)

Petitioner's course of physical therapy at Athletico commenced on May 12, 2016 and continued through August of 2016. Petitioner regularly saw Dr. Gonzalez for follow-up during this course of treatment. (PX 13) On August 23, 2016, Dr. Gonzalez determined that Petitioner continued to suffer weakness in his thumb and was now demonstrated tendinitis in digits 2 through 5 as well. Dr. Gonzalez directed Petitioner to undergo additional work conditioning and occupational therapy. The doctor ordered Petitioner to return in 4 to 6 weeks for continued treatment of his hand condition. (PX 4)

Following this interval treatment by Dr. Gonzalez, Petitioner returned to see Dr. Domb for continued treatment of the hip condition.

On August 25, 2016, Dr. Domb renewed his recommendation for surgery. (PX 10)

On November 16, 2016, which was more than two weeks after he passed the final phase of pre-op assessment at Little Co. of Mary Hospital, Petitioner underwent a MAKOplasty robotic guidance right hip replacement at Munster Specialty Surgery Center. Dr. Domb performed this surgery. (PX 14)

Two days after the surgical intervention, Petitioner returned to see Dr. Domb's nurse

practitioner and then continued to follow up approximately every week until he commenced physical therapy at ATI on December 5, 2016. (PX 15) At visits of December 8, 2016 and January 18, 2017, progress was mapped. (PX 10) Physical therapy continued throughout December and into January of 2017. (PX 15)

Petitioner returned to see Dr. Slack on January 9, 2017, and advised the doctor of his right hip replacement procedure. Petitioner noted that during rehab for this procedure, he had a flare-up of right-sided lower back pain especially with sitting for any length of time or even lying down. On physical examination, Petitioner demonstrated a slow, deliberate gait on ambulation and exhibited pain in the right buttock and lower back with forward flexion. The doctor determined that Petitioner's pain flare-up in his right lower back, buttocks, and posterior thigh related to an irritation of his lumbar spondylosis subsequent to his altered gait pattern that resulted from the hip surgery. Dr. Slack recommended that Petitioner see an anesthesia pain specialist for facet injections and also for radiofrequency lesioning, if possible. After prescribing a Medrol Dosepak, Neurontin, and home exercises, Dr. Slack released Petitioner to return to work with restrictions that consisted of a 25-lbs. lifting, no repetitive bending, twisting or lifting, and that he must be able to change positions every 30 minutes to avoid prolonged sitting/standing. (PX 4)

Petitioner continued to follow up with Dr. Domb. (PX 10)

On January 16, 2017, Dr. Joseph Rabi saw Petitioner and administered a steroid intra-articular injection to his sacroiliac joint. (PX 16)

On January 17, 2017, Petitioner saw Dr. Gonzalez in follow up for the right hand/wrist

surgery. Petitioner reported that his right hand is doing well and that his grip strength has been improving. He also reported to the doctor that since his last visit, he underwent a total hip arthroplasty on the right side and received an epidural injection in the lumbar spine. Petitioner, 61 years old at that time, then reported that his knee has actually been bothering him on the right side and mentioned an old injury sustained during a fight in 1990 that has been acting up more recently. He also mentioned to Dr. Gonzalez that his knee has also been bothering him more since the total hip replacement. Dr. Gonzalez ordered x-rays of the right knee. Such images revealed moderate degenerative joint disease. Dr. Gonzalez recommended physical therapy for the right knee and advised Petitioner to exercise caution when performing any kind of kneeling or twisting motion with the affected knee. (PX 4)

Petitioner thereafter followed up with Dr. Domb and continued with physical therapy at his direction. Upon returning to Dr. Domb on February 23, 2017, Petitioner complained of ongoing right hip and lower back pain, as well as increasingly problematic pain in his right knee. The doctor recommended an MRI of the knee to rule out a meniscus tear and ordered Petitioner to return in three months for new x-rays and review of the MRI results. (PX 10)

Petitioner then saw Dr. Rabi on March 6, 2017. On this date, Dr. Rabi performed a steroid intra-articular injection - facet to treat Petitioner's lumbar facet arthopathy. Dr. Rabi thereafter advised Petitioner to call to report the level of pain relief and to schedule "RF ablation R SI and R L5, S1." (PX 16)

Petitioner followed up with Dr. Domb in March of 2017 and with Dr. Rabi in April of 2017.

Each of the doctors who treated Petitioner subsequent to his May 3, 2012 injury continued to advise that he could return to work with only light-duty restrictions.

Petitioner testified that he is currently under the care of Dr. Slack and Dr. Domb. Petitioner testified that he has upcoming appointments with both physicians. Petitioner reviewed PX 17, which is a compendium of the outstanding medical bills that total $278,247.94. Petitioner agreed with Petitioner's Counsel that he has had co-pays, or deductibles, that total $752.40. He also agreed with Petitioner's Counsel that $5,190.90 in medical bills have been paid by Blue Cross/Blue Shield. Petitioner testified that as far as he knows, such bills remain unpaid. (Tr. 74-76)

On cross-examination, Petitioner testified that he is doing home exercises for his hip and back. He does not currently participate in any formal physical therapy regimen for his hip, but is to follow up with Dr. Domb in three months. Petitioner testified that he is actively treating for his back, and is to see Dr. Slack after his last visit with Dr. Rabi.

On September 8, 2015, Jay Lawrence Levin, M.D., testified, via deposition, on behalf of Respondent.

On October 6, 2015, Daniel A. Troy, M.D., testified, via deposition, on behalf of Respondent.

On December 2, 2015, Charles M. Slack, M.D., testified, via deposition, on behalf of Petitioner.

On July 18, 2016, Benjamin G. Domb, M.D., testified, via deposition, on behalf of Petitioner.

CONCLUSIONS OF LAW

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?," the Arbitrator finds as follows:

Respondent stipulated to the issue of accident, but disputes the issue of causation. (AX 1, Section 2)

Accordingly, the Arbitrator addresses the issue of whether Petitioner's current conditions of ill-being of his right hip, low back, right hand/wrist, and right knee are causally related to the May 3, 2012 accident.

Physicians' Testimony:

Dr. Jay Levin testified on September 8, 2015. He is an orthopedic surgeon who has done a fellowship in spine surgery. His curriculum vitae indicates that he is board-certified in independent medical examining through August 2017 and in orthopedic surgery through March 2018. (RX 3, pp. 1-2, Dep Ex. 1)

Dr. Levin performed a Section 12 examination of Petitioner's right hip on April 17, 2013. After taking a history from, and conducting an examination of, Petitioner, after reviewing medical records and imaging studies, Dr. Levin diagnosed him with non-traumatic right hip avascular necrosis with corresponding changes in the right hip acetabulum consistent with degenerative arthritis. (RX 3, pp. 6-8, Dep. Ex. 2) Dr. Levin testified that Petitioner's changes in his right hip, as reported and stated in his reports, predated the May 3, 2012 occurrence, and in fact, the activity Petitioner described to him, is consistent with him having symptoms from the

underlying avascular necrosis ("AVN") of the right hip. (RX 3, pp. 10-11)

Dr. Levin testified that he did not feel that the activities Petitioner performed on May 3, 2012 caused or aggravated his current symptoms of ill-being of the right hip. (RX 3, p. 12) Dr. Levin testified that as a differential diagnosis, Petitioner's right leg could have given out on May 3, 2012 because of avascular necrosis in the right hip; imaging tests taken after the fall indicate a FICAT Grade 3 degree of AVN. (RX 3, pp. 13-14) Dr. Levin testified that it was inferred that his complaints were in different areas. (RX 3, p. 14) Dr. Levin testified that "any activity, if in fact there is a forced application which created pain and a lack of strength, could result in a hip giving out with the anatomical findings that are present in this man's hip from avascular necrosis." Such giving out could have occurred at home. (RX 3, pp. 14-15)

Dr. Levin further testified that, when considering the pain experienced thereafter and the July 16, 2012 MRI of the right hip, the act of stepping down 2 feet would not aggravate Petitioner's avascular necrosis. (RX 3, pp. 15-16) When asked if the right hip treatment Petitioner received following the May 3, 2012 accident was medically necessary and related, Dr. Levin testified that the issue Petitioner is having with his right hip is not related to the May 3, 2012 occurrence.

On cross-examination, Dr. Levin testified that for the sake of thoroughness, he included a reference to Petitioner's Application for Adjustment of Claim. (RX 3, p. 20) Dr. Levin testified that he did not include references to some of Dr. Pye's records because he did not have such records. (RX 3, p. 21) Dr. Levin testified that in his May 10, 2013 report, he referred to all the records that were supplied to him by the employer. (RX 3, p. 46) Dr. Levin agreed with

Petitioner's Counsel that AVN occurs when the blood supply to the femoral head is compromised and can sometimes be congenitally, or sometimes genetically caused, or maybe due to some other etiology. Uses of steroids or some types of medication can bring about AVN. Exposure of the hip to radiation can result in AVN. A fracture or dislocation of the hip in which there is an interruption of the blood supply can cause AVN.

Dr. Levin testified that any trauma to the hip could probably result in AVN, although a fracture, a fracture dislocation, or a pure dislocation would be the most likely types of trauma to cause it. (RX 3, pp. 23-25) Dr. Levin opined that AVN was present prior to the May 3, 2012 injury. He also opined that the natural history of the process of AVN is that most of the time it progresses from grade 0 to grade 4. (RX 3, pp. 27-28, 40)

Dr. Levin testified that, from his interpretation and the radiologist's interpretation, the July 16, 2012 MRI of the right hip does not show edematous changes. Also, the doctor opined that the September 5, 2012 CT scan of the right hip does not show anything that would be consistent with an event of traumatic etiology. (RX 3, pp. 28-29) Dr. Levin testified that there is no evidence Petitioner sustained a fracture from the May 3, 2012 fall. He also testified that if one believes that there is a temporal relationship regarding the interruption of blood supply, one would see that on the MRI probably 10 days later. (RX 3, pp. 30-31) Dr. Levin believed the radiologist's finding regarding the right femoral head is that it is comparable to osteonecrosis without an acute component at that time. Dr. Levin's interpretation of the July 16, 2012 MRI of the right hip is that there is absent neuroedema, which suggests this is a non-acute process. (RX 3, pp. 31-32) When asked if edema must be present. Dr. Levin testified "Nothing in the world is

a must." (RX 3, p. 32) Dr. Levin did not expect to see edema because Petitioner has AVN of the right hip. (RX 3, pp. 32-33)

Dr. Levin's interpretation of the MRI is that Petitioner has a FICAT Grade 3 AVN of the hip, and had a painful hip because of that. (RX 3, p. 33)

Dr. Levin also agreed that Dr. Shana Landau identified a tear of the superior anterior labrum of the right hip on the September 5, 2012 MRI. When asked if the tear, as evidenced by the study, could be a result of the fall, Dr. Levin answered: "Anything is possible. I defer to his treating physician, Dr. David Smith, September 28, 2012 visit for that comment." (RX 3, pp. 37-39)

On cross-examination, Dr. Levin testified that after examining Petitioner on April 17th and after later reviewing the records, he concluded that Petitioner needed some treatment for his left hip. (RX 3, p. 39)

Dr. Levin then testified:

Q: Okay. So, when he fell on his right side, simply put, could that have been a factor in worsening his symptoms as he complained to Dr. Pye commencing on May 3rd going forward?

A: Here is my answer on that. Anything is possible. I think it does not appear to be the factor for the reasons stated in my report including the assessments done thereafter. But anything in this world is possible. It could be a factor. I don't think it is the factor or a significant factor.

Q: Well, I agree with you, it's not a significant factor. But my question, Doctor, is this.

Could that blow to the right side of his body, which he talked about and your nurse documented, could that be a factor, small A, could it be a piece, could it be some factor that led him to complain and develop the symptoms as he reported to Dr. Pye, yes or no?

A: I need the definition of the word "A."

Q: A, small A, a piece, like a straw on the camel's back.

A: Anything is possible. (RX 3, p. 41)

Dr. Levin then stated that "generically if the standard we're using is anything in this world is possible, I'll never state that anything in this world is not possible. But I don't think it is medically reasonable for reasons in my report and my testimony." (RX 3, p. 42) Dr. Levin opined that Petitioner would have experienced a natural progression of AVN based on the MRIs and based on the fact that Petitioner already had another hip problem in the past without any history of necessarily an acute trauma. (RX 3, pp. 42-43) The fact that Petitioner had a left hip replacement in the past is, in and of itself, not the major factor. (RX 3, p. 43)

Dr. Levin testified that he was not made aware that Petitioner had suffered an injury on October 16, 2009, and was not made aware that he had been worked up for right hip complaints during the course of that treatment. (RX 3, p. 44)

Dr. Levin testified that Petitioner presented to him for an examination of his right hip. He did not examine Petitioner for his back. (RX 3, p. 39)

Dr. Daniel Troy testified on October 6, 2015. He testified that his curriculum vitae is current and accurate. Such c.v. indicates that Dr. Troy is an orthopedic surgeon who has done

fellowships in spine surgery and sports medicine, and that he passed Part I of the board-certification exam on July 14, 2000, and Part II of the board-certification exam on July 21, 2005. (RX 4, p. 4, Dep. Ex. 1)

Dr. Troy performed a Section 12 examination of Petitioner on January 16, 2014. He saw Petitioner with regard to a May 3, 2012 injury and an October 16, 2009 injury. Dr. Troy testified that the purpose of meeting with Petitioner was to evaluate him for his right hip and low back. (RX 4, pp. 5-7) He testified that he has already given opinions with respect to causation and whether the accidental injuries of May 3, 2012 and October 16, 2009 were related to his work activities and he opined that they were not. Dr. Troy also reviewed medical records reflecting the extensive amount of treatment Petitioner received. (RX 4, p. 7) Dr. Troy concluded that since Petitioner has a significant pre-existing history of avascular necrosis of the bilateral hips, Petitioner's low back symptoms were generated secondary to his hip problems. Petitioner had a left total hip arthroplasty in the past secondary to AVN, and with regard to the 2012 injury, Petitioner reported that his right leg gave out. (RX 4, pp. 7-8) Dr. Troy testified that with AVN, one can generate a possible antalgic gait that can lead to right gluteal symptoms, essentially the buttock area, that can cause one to have back symptoms secondary to an antalgic gait. (RX 4, p. 8)

Dr. Troy testified that it is common to see left and right hip avascular necrosis because when the cause has been idiopathic due to alcohol use, steroid use, or other causes, it is very common for it to affect both joints. (RX 4, pp. 9-10)

Dr. Troy testified that repetitive bending, and falling from a three-foot high space could

cause back pain. With regard to a fall, he opined that just the force of striking the ground across the lumbar spine could cause pain. The twisting of the fall could cause pain. (RX 4, p. 10) He testified that Petitioner stated to him that he landed on his right side and injured his wrist and back at the time. (RX 4, p. 12)

On cross-examination, Dr. Troy testified that he is board-certified in spinal surgery, general orthopedics, and sports medicine. (RX 4. 12-13) Dr. Troy was unable to cite to a specific peer review study that indicates the etiology of AVN. (RX 4, pp. 20-21) Dr. Troy further testified that avascular necrosis is initially treated with anti-inflammatory medication to address the pain. To treat the AVN itself, different proposals include core reaming to induce blood supply to the femoral head. This procedure can be augmented with bone marrow aspirate. Another procedure, as pioneered by Duke University, consists of free vascularized fibular grafting. The ultimate treatment for AVN would be conversion to a total hip replacement. (RX 4, pp. 22-23)

Dr. Troy testified that he charges $1,225.00 for an IME, and $1,000.00/hour for a deposition. (RX 4, p. 29)

Dr. Troy testified that he dated Petitioner's long-standing history of bilateral hip AVN back to the June 10, 2010 MRI of the pelvis. Dr. Troy did not have the MRI films from that date, only the report. Dr. Troy felt that the MRI presence of AVN means that he has got at least a FICAT II. (RX 4, pp. 29-32)

Dr. Troy testified that, per year, he performs between approximately 80 and 100 spine surgeries, between 75 and 100 shoulder surgeries, between 25 and 50 hand surgeries, and treats between 50 and 100 AVN patients. He works 50 weeks a year. (RX 4, pp. 33-34)

Dr. Troy testified that the doctor's determination in the first MRI report is that Petitioner's AVN is at a Grade I. (RX 4, pp. 34-35)

Dr. Troy agreed with Petitioner's Counsel that based upon the report of the patient (Petitioner) on the first day of the injury, the treating doctor felt that it was appropriate to investigate the right hip and ordered x-rays of the hip. (RX 4, pp. 36-37) Dr. Troy did not review the x-rays of the right hip, lumbosacral spine, and right elbow from that date as they were not available to him. Dr. Troy did not review the CT films of the CT scan done on September 5, 2012. (RX 4, p. 45)

Dr. Troy felt that the treatment Petitioner received from Dr. Pye and Dr. Slack was appropriate for the complaints and condition as discovered by the diagnostic studies. (RX 4, pp. 38-39)

Dr. Troy testified that it was on August 13, 2012, that Dr. Pye directed Petitioner to Dr. Smith specifically for the right hip. (RX 4, p. 39)

Dr. Troy testified that a blow directly to the right hip could be a factor in creating symptoms or causing further anatomical damage, including a soft tissue contusion, and that theoretically, it could cause an acceleration of the avascular necrosis. However, Dr. Troy's position was that Petitioner's AVN of the right hip was pre-existing and that there is no direct cause of his AVN from the May 3, 2012 injury. (RX 4, pp. 41-42) Aseptic necrosis is exactly the same condition as avascular necrosis. (RX 4, p. 43)

Dr. Troy testified that subsequent to the 2012 injury, the vast majority of Petitioner's complaints, 90+%, were related to his low back. (RX 4, pp. 44-45) With regard to the labral tear

identified the September 5, 2012 MRI of the right hip, Dr. Troy testified that it could be present secondary to the paralabral cyst and was "highly probably" not the result of a direct blow. If Petitioner fell off the truck, landed on his right leg and then twisted and fell onto his right side, that sequence of events would possibly be a competent source of the labral tear. (RX 4, pp. 46-47)

Dr. Troy testified that, prior to the morning of the deposition, he did not have the opportunity to review any treating records subsequent to August 29, 2013. (RX 4, p. 48)

Dr. Troy and Petitioner's Counsel agreed that Petitioner had AVN prior to May 2012. (RX 4, p. 48)

Dr. Troy agreed that he wrote the following in his report: "The complaints of pain to the right hip are being generated from non-worker's compensation-related avascular necrosis of his hip." The doctor denied that such statement implies that he understands the workers' compensation elements in law. (RX 4, p. 49) Dr. Troy testified that, although he did not review the films of either the 2009 MRI or 2012 MRI, he disagrees with the radiologist's conclusion of a new finding of AVN because there is documentation in the 2009 report of a presence of Grade I AVN. (RX 4, pp. 51-52)

Dr. Troy then testified to the following:

Q: Okay. So you're saying that there was absolutely no relationship, I mean, zero, between that fall on the right side, the complaints of ill-being, and the continuum of AVN after May 3rd of 2012? Zero involvement.

A: He had documentation of AVN prior to the fall. He fell. He continued to demonstrate no further change in AVN. There's no further femoral head collapse. He reported that when he was getting down from the truck, that his leg buckled and it gave out, therefore leading to the fall. Therefore, my previous opinion stands. (RX 4, pp. 52-53)

Dr. Troy testified that 25-30% of individuals who have AVN of one hip have it in the other hip. (RX 4, p. 54)

The doctor also testified that the activities of bending forward, twisting the pull leveler, and experiencing pain in the lower back would be a low probability for causing AVN of the hip. (RX 4, p. 55) The doctor also testified that when Petitioner presented to him, Petitioner went through the sequence of events and recalled exactly how he hurt himself. (RX 4, p. 56)

Dr. Troy testified that there is no evidence in his file of the contemporaneous notes that he took at the time he examined Petitioner and that such notes have been incorporated into his IME report. (RX 4, p. 58)

On redirect examination, Dr. Troy testified that when he states his opinion is based on medical certainty, such opinion includes the reading he does to keep up-to-date in orthopedics as well as his re-certification in orthopedic surgery and completion of an extensive review course. (RX 4, p. 59) The doctor further testified that it's not uncommon to see AVN in one hip after there was a previous finding of AVN in the other hip. (RX 4, p. 60) Dr. Troy testified that in the 2010 MRI of the right hip, Petitioner demonstrated FICAT Stage II of AVN, and that in the second MRI, he again demonstrated FICAT Stage II. (RX 4, p. 61) The doctor also testified that

AVN could cause pain, which could possibly cause the leg to give out. (RX 4, p. 61)

On recross examination, Dr. Troy testified that the FICAT stages have been broken down into sub-stages. (RX 4, pp. 62-63)

Dr. Charles Slack testified on December 2, 2015. He testified that his curriculum vitae is up to date and current. The doctor is an orthopedic surgeon who also did a spine fellowship. He limits his practice to patients with spinal conditions. His c.v. indicates that in September 1979, he was certified by the American Board of Orthopaedic Surgery. (PX 18, pp. 4-5, Dep. Ex. 1)

Dr. Slack testified that he first saw Petitioner in March of 2010 upon a referral from Dr. Pye. Petitioner related to him facts surrounding an episode or accident on October 16, 2009. Dr. Slack examined Petitioner. Petitioner failed to bring him a CD of the MRI. He took Petitioner off work. As Petitioner had a favorable response to a diagnostic facet block, Dr. Slack, on June 7, 2010, recommended radiofrequency lesioning of the facet joints in his back. Respondent did not approve this procedure. Petitioner returned to Dr. Slack on July 15, 2010. Dr. Slack kept Petitioner off work. (PX 18, pp. 6-10)

Dr. Slack testified that Petitioner apparently went back to work and subsequently had an incident in May of 2012, for which Petitioner came to see him. Petitioner returned to see Dr. Slack on August 22, 2012. (PX 18, p. 10) Dr. Slack testified that as of July 2010 he was still waiting for approval for this procedure, and so Petitioner was still off work. (PX 18, p. 11) So, Petitioner came to see him approximately 2 years after a second industrial injury. Petitioner advised him that he was having symptoms in his hip, for which he was seeing Dr. Smith. (PX 18, p. 12)

When he saw Petitioner on November 8, 2012, Dr. Slack reviewed Petitioner's MRI and determined that Petitioner was capable of returning to modified-duty work. (PX 18, p. 12)

Petitioner continued to treat with Dr. Slack. Petitioner mentioned that he had continuing hip issues, for which he was seeing Dr. Smith. (PX 18, p. 12)

In February 2014, Petitioner returned to Dr. Slack and reported that he had undergone the diagnostic facet block and radiofrequency ablation. Petitioner had noticed some improvement in his right leg and lower back. Dr. Slack was hopeful that his improvement would continue. (PX 18, pp. 16-17) Dr. Slack saw Petitioner on April 10, 2014, at which time he was not working but still under modified-duty restrictions. Dr. Slack also saw Petitioner on May 22, 2014, then on December 8, 2014. Dr. Slack was still recommending treatment for his back. (PX 18, pp. 17-19)

Dr. Slack testified that he has an opinion within a reasonable degree of medical and surgical certainty that both of the events were aggravating factors to his underlying condition. (PX 18, pp. 21-22)

Dr. Slack testified that when he saw Petitioner on March 30, 2015, he mentioned that he had seen Dr. Mike Jablon. Dr. Slack referred Petitioner to Dr. Jablon sometime in March to discuss a problem with his hand. (PX 18, p. 24)

Dr. Slack reviewed a lumbar MRI of April 30, 2015, and based on that and a discussion with Petitioner, recommended that he stay active in his exercise program and continue with the work restrictions the doctor had imposed. He has recommended another facet lesioning procedure. Dr. Slack has not declared Petitioner to be at MMI. (PX 18, pp. 25-26)

On cross-examination, Dr. Slack testified that he saw Petitioner for both of the alleged

accidents; the first was in 2010 and the second was in 2012. He further testified that he believes Petitioner did have the facet lesioning, or ablation, sometime after the first incident, but pain relief from such procedure lasts 9 months to a year before the nerves begin to regenerate and the pain recurs. (PX 18, pp. 28-30) Dr. Slack testified that he did not have the opportunity to review medical records from any other doctor for the period of July 15, 2010 through August 22, 2012. (PX 18, p. 30) The doctor testified that Petitioner did have the diagnostic facet blocks and facet lesioning in February 2014, from which he received some improvement in his low back and leg pain. (PX 18, p. 34) Dr. Slack noted that the MRI scan indicated that he has a combination of degenerative disc bulging at L4-5 in addition to the facet arthritic change. (PX 18, pp. 35-36) The concern was that there may be a component of pain also coming from the degenerative disc. (PX 18, p. 36)

Dr. Slack testified that it is usually not the case that the right lower back pain, about which Petitioner complains, is actually coming from the hip. When there is a problem with the hip joint, pain can be just in the groin or in the groin and just the front of the thigh, but not below the knee and not in the back. (PX 18, pp. 38-39) When Petitioner came to see him in 2010, he had similar complaints of right low back pain going into the thigh. Dr. Slack testified that a blow to the femoral head could cause pain in the right hip if the hip is already compromised and not normal. Dr. Slack testified that he did not document that Petitioner fell on his right hip. Prior to seeing Petitioner on August 22, 2012, Dr. Slack did not have an opportunity to review any of the documents relating to the May 2012 injury. Petitioner reported to him that his back was giving him problems and he fell. Petitioner has scheduled an appointment with Dr. Slack, but the

doctor does not recall the date of such appointment. (PX 18, pp. 39-41)

Dr. Benjamin Domb testified on July 18, 2016. Dr. Domb testified that hip surgery is the focus of his practice. He does arthroscopy of the shoulder, hip, and knee, but the majority of his work, his teaching, and his publishing has been in hip surgery. That is reflected in his c.v. (PX 19, p. 11)

Dr. Domb first saw Petitioner on October 29, 2015. Petitioner provided Dr. Domb with a history of the alleged injury that occurred at work. The history Petitioner provided to him was that of a 2009 trauma to his low back for which he complained of right-sided pain. Petitioner also related to him a second occurrence that happened in May of 2012. (PX 19, pp. 5-6)

At his November 23, 2015 visit to Dr. Domb, Petitioner told him that he had an injury in 2009 and then another injury involving his back and right hip in 2012 when he was getting out of a machine and was having recurrent back pain, stepped on a wet step of the machine and slipped. At that time, Petitioner noted immediate onset of severe back pain as he had in the past. Dr. Domb further testified that Petitioner stated that such pain was so severe that when he twisted on the left step, he fell and landed on his right hip. He had to have someone help him off the ground. He complained of pain in the anterior groin, which was severe, especially with walking, bending, and activity. (PX 19, p. 7)

At that point in the deposition, Petitioner's Counsel moved to editorially amend Dr. Domb's statement as he stated that the evidence to be presented, which has been discussed in prior depositions, is that Petitioner fell approximately 3-4 feet off the machine and landed on his right side and hip. (PX 19, p. 7)

Dr. Domb testified that he examined Petitioner, reviewed some MRIs, and formed an opinion as to Petitioner's condition: right hip avascular necrosis ("AVN") of the femoral head. Dr. Domb testified that AVN is not thought to be part of normal aging, and can certainly be caused by trauma. It can also occur in the context of rheumatolgic diseases such as lupus. (PX 19, p. 8)

Dr. Domb agreed with the proposition that approximately 25% of people who have AVN in one hip will have AVN in the other hip. (PX 19, p. 9)

Dr. Domb testified that after he saw Petitioner and worked him up, he recommended that he undergo a hip replacement, specifically, an anterior approach robotic hip replacement of the acetabulum and femoral head using a Mako robot. Dr. Domb hopes that the majority of such hip replacements will last more than 15 to 20 years. (PX 19, pp. 9-10)

Dr. Domb responded "Yes" to the following question:

> "Do you have an opinion within a reasonable degree of surgical certainty, that given the fact that avascular necrosis may have predated his 2012 accident, but there was never a recommendation for any surgical treatment or aggressive treatment, could or might his fall, where he landed directly on the right hip and on the right side, could that have aggravated and accelerated any preexisting component that we've now called avascular necrosis?" (PX 19, p. 13)

Dr. Domb further testified that it appears that Petitioner may have had AVN, probably Stage I, prior to the injury but did not have symptoms that warranted a hip replacement before

the injury. So, a direct blow to the hip would be expected to cause microfractures within the compromised bone, and, potentially lead to a collapse of the femoral head, any or all of which would increase pain to the extent of needing a hip replacement. (PX 19, pp. 13-14)

Dr. Domb testified that it would be fine for Petitioner to participate in a sedentary or light-duty situation. (PX 19, p. 15)

On cross-examination, Dr. Domb testified that there was the possibility of microfractures in his femoral head, but that one would not see microfractures on film, but would see edema, which is swelling in the bone around the microfractures. Dr. Domb testified that he viewed the actual MRI film that was taken on September 5, 2012. (PX 19, p. 16)

Dr. Domb testified that when he first saw Petitioner, he was told by Petitioner that his pain began in 2009, and that there was no mention of the 2012 incident on that date. He testified that Petitioner told him that he was diagnosed with AVN in 2012. Petitioner told him that he drank alcohol occasionally. Dr. Domb testified that there is a correlation between excessive alcohol intake and AVN. Dr. Domb testified that he did not note that Petitioner had long-term use of steroids. Dr. Domb agreed with Respondent's Counsel that it was not until he saw Petitioner in November of 2015 that he actually mentioned the 2012 fall. (PX 19, pp. 17-18)

Dr. Domb testified that his records indicate that he had direct trauma to this hip, but did not say how far he fell or what type of surface he fell on, other than "the ground." (PX 19, p. 19)

He testified that he may have reviewed prior records when he first saw Petitioner, but he does not recall. Dr. Domb did not review the MRI of 2010. He testified that all treatment decisions in a 60-year-old with AVN are based on symptomatology, not on MRI appearance. Dr.

Domb further testified that, essentially, it would not be relevant to see the MRI appearance at different time intervals in deciding his treatment. (PX 19, p. 8)

Dr. Domb testified, hypothetically, that pain from AVN could cause Petitioner to fall. (PX 19, pp. 21-22)

The doctor testified that he could not tell from the 2012 MRI whether the AVN was old or new. (PX 19, p. 22)

He further testified that when he saw Petitioner, his right femoral head was at Stage II AVN, and that a recommendation for a total joint replacement in a 60-year-old is based upon the patient's symptomatology. Dr. Domb would rarely try core decompression surgery on a 60-year-old patient. Petitioner received an intraarticular cortisone injection as well as medical treatment with Diclofenac, Norco and supplements.

On redirect examination, Dr. Domb testified that the work status note dated October 29, 2015, the date of his initial intervention with Petitioner, indicates that the date of injury ("DOI") was "5-3-12." Dr. Domb agreed that although there may have been an omission of a discussion of the May 3, 2012 injury in the chart note of October 29, 2015, he did indicate an insult date of May 2012 in the work status note. (PX 19, p. 25)

On recross examination, Dr. Domb testified that his assistant types up the work status note at the time of the patient's visit. (PX 19, p. 26)

In Sisbro, Inc. vs. Indus. Comm'n, 207 Ill.2d 193, 797 N.E.2d 665 (2003), the Supreme Court was faced with the issue of determining whether or not claimant's prior ankle condition was aggravated and accelerated by an accidental injury to that member.

Claimant was a delivery truck driver, who, in the course of his employment, twisted his right ankle when he stepped down out of the truck and into a pothole. Claimant testified that at the time of the incident, he felt pain in the ankle and it swelled slightly. Within a few days, the swelling and pain resolved. Eleven days after the injury, he visited his podiatrist for preventative foot care in relation to his diabetes. Claimant reported the pothole incident to the podiatrist. Claimant had no pain or swelling in the right ankle at the time of this visit. However, over the next few weeks, claimant's ankle began to swell repeatedly, and the swelling would not resolve. Approximately one month after the pothole incident, claimant was diagnosed with Charcot osteoarthropathy, and ordered to stay off the foot. Medical evidence was presented that indicated that when claimant twisted his ankle in the course of his employment, it caused the onset of Charcot osteoarthropathy, which is a condition peculiar to those with diabetes. Claimant suffered from diabetes.

The Commission found that the injury did, in fact, aggravate the pre-existing condition and that claimant was entitled to benefits pursuant to the Act.

Thereafter, the Circuit Court of Adams County confirmed the Commission's decision and an appeal was taken to the Appellate Court.

In a decision published by the Appellate Court under 327 Ill.App.3d 868, 262 Ill. Dec.

46, 764 N.E.2d 1163, the Appellate Court, in a split decision, reversed the judgment of the Circuit Court, and found that claimant's condition was not compensable because his health had so deteriorated that any normal, daily activity could have caused the injury or because the activity in which he engaged presented risks no greater than those to which the general public is exposed. 327 Ill.App.3d 868.

The majority further held that the Arbitrator found that claimant's accident of March 19, 1998 caused the Charcot, but did not consider whether claimant nonetheless should be barred from compensation in light of uncontradicted testimony that normal daily activities were sufficient to cause Charcot in claimant. Moreover, they held that the Commission, in reviewing the findings of the Arbitrator, did not consider either of the two exceptions to the rule permitting compensation for work-related aggravation of a pre-existing condition. Because they determined that this case fell into one of those exceptions, the majority held that the Commission's award of compensation was against the manifest weight of the evidence. Thereafter, the Supreme Court granted the Petition for Leave to Appeal.

In analyzing the Appellate Court's decision as well as the facts of the entire case, the Supreme Court stated "to obtain compensation under the Act, a claimant bears the burden of showing by a preponderance of the evidence, that he suffered a disabling injury which arose out of and in the course of his employment." Baggett vs. Indus. Comm'n, 201 Ill.2d 187, 775 N.E.2d 908 (2002).

"In the course of" employment refers to the time, place and circumstances surrounding the injury. That is to say, for an injury to be compensable, it generally must occur within the

time and space boundaries of employment. 1 A. Larsen, Workers' Compensation Law, Section 12.01 (2002). It is not enough however to simply show that an injury occurred during working hours or at the place of employment, the injury must also arise out of the employment. Parro vs. Indus. Comm'n, 167 Ill.2d 385, 657 N.E.2d 882 (1995).

The Court stated that the "arising out of" employment component is primarily concerned with causal connection. 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. Caterpillar Tractor Co. vs. Indus. Comm'n, 129 Ill.2d 52, 541 N.E.2d 665 (1989).

The Court disagreed with Sisbro's contention that even when a work-related accidental injury is shown to be an *actual* causal factor in bringing about an employee's disabling condition, recovery should be denied if normal daily activity *could* have brought on claimant's disabling condition.

The Court concluded:

> "In the present case, the Commission found that claimant's March 26, 1998, work-related accidental injury was causally related to the claimant's Charcot. Based on our review of the record, we find that it may be legitimately inferred from the evidence before the Commission that occupational activity was, in fact, a causative factor in hastening claimant's contraction of Charcot. Accordingly, we reverse the judgment of the appellate court and affirm the decision of the circuit court."

The Supreme Court also held:

"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 (supra)

In the case at bar, the Arbitrator finds that as a result of Petitioner's fall from the Vactor machine on May 3, 2012, he aggravated the pre-existing conditions of his right hip and low back thereby resulting in the need for treatment for both body parts. Therefore, the Arbitrator finds the current conditions of ill-being of Petitioner's right hip and low back to be causally related to the accident of May 3, 2012.

With regard to the right hip, the Arbitrator primarily relies on (1) the medical records, which indicate consistent complaints of right hip pain since the May 3, 2012 fall, positive tenderness to palpation of the right greater trochanter, a 3 x 4 centimeter area of induration and ecchymosis on the proximal lateral aspect of right hip, a referral by Dr. Pye to Dr. Smith for his hip condition, with whom Petitioner began treating on August 13, 2012, and (2) the opinions of

Dr. Domb.

Dr. Levin testified that, from his interpretation and the radiologist's interpretation, the July 16, 2012 MRI of the right hip does not show edematous changes.

Dr. Domb testified, within a reasonable degree of surgical certainty, that given the fact that avascular necrosis may have predated his 2012 accident, but with no recommendation for any surgical treatment or aggressive treatment for such condition, that the fall in which he landed directly on the right hip and on the right side, could or might have aggravated and accelerated any pre-existing condition of avascular necrosis. (PX 19, p. 13) As a basis for his opinion, Dr. Domb testified that he viewed the actual, September 5, 2012 MRI films of Petitioner's right hip, and noted edema, which is swelling in the bone around the microfractures. (PX 19, p. 16)

Dr. Levin, Respondent's examining physician for the hip, is a board-certified orthopedic surgeon. However, Dr. Levin also testified that 50% of his practice involves treatment of the back. (RX 3, p. 39)

The Arbitrator has also considered Dr. Troy's opinions about the right hip.

Dr. Domb, one of Petitioner's treating orthopedic surgeons for the hip, testified that hip surgery is the focus of his practice. Although he does arthroscopic surgeries of the shoulder, hip, and knee, the majority of his work, his teaching, and his publishing have been in hip surgery. (PX 19, p. 11)

The Arbitrator finds the opinions of Dr. Domb to be more persuasive than those of Dr. Levin or Dr. Troy. As hip surgery is the focus of Dr. Domb's practice, the Arbitrator finds him more qualified than Dr. Levin or Dr. Troy to render an opinion on Petitioner's right hip.

Even if one of the medical witnesses was equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinion of the treating physician. International Vermiculite v. Indus. Comm'n, 394 N.E.2d 1166 (1979).

In this case, with regard to the issue of causation for both the low back and right hip, the Arbitrator gives greater weight to the opinions of the treating physicians.

With regard to Petitioner's low back, the Arbitrator relies on the medical records, which reflect his consistent complaints of back pain since the accident, as well as on the opinions of Charles M. Slack, M.D., his treating physician. The Arbitrator finds Dr. Slack's opinions to be more persuasive than Dr. Troy's opinions.

Dr. Slack testified that he has an opinion within a reasonable degree of medical and surgical certainty that both of the events were aggravating factors to his underlying condition. (PX 18, pp. 21-22)

Dr. Troy wrote: "The claimant, from my standpoint, appears to have intermittent symptoms to the low back area being aggravated from the AVN of his right hip. This is overall non-Worker's Compensation related." (RX 4, Dep. Ex. 2)

Dr. Slack, however, testified that it is usually not the case that the right lower back pain, about which Petitioner complains, is actually coming from the hip. When there is a problem with the hip joint, pain can be just in the groin or in the groin and just the front of the thigh, but not below the knee and not in the back. (PX 18, pp. 38-39)

With regard to Petitioner's right hand/wrist, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the May 3, 2012 accident, and that the need for the surgery Dr. Gonzalez performed on March 14, 2016 was causally related to such accident. Such surgery consisted of a ligament reconstruction and tendon interposition of the right thumb carpometacarpal joint and trapeziectomy. The pre-operative and postoperative diagnoses were "Right thumb stage IV carpometacarpal joint arthritis." (PX 12)

The Arbitrator notes that there is no mention of a right hand/wrist injury in either the May 3, 2012 "Report of Occupational Injury or Illness" or the May 3, 2012 record of Petitioner's visit to Dr. Bartolome. (RX 7, RX 1) Dr. Bartolome ordered x-rays of the right elbow, lumbar spine, and right hip and provided diagnoses of right elbow abrasion, lumbar strain, and right hip strain.

On May 7, 2012, however, Dr. Pye examined him and wrote, in pertinent part, the following:

> "RT HAND: NORMAL, NEG. ABRASIONS, NO CREPITUS OR DEFORMITY NOTED. INSPECTION OF WRIST WAS NORMAL. AROM: NORMAL. NORMAL FOR DF, PF, RD, AND UD. FULL ROM OF ALL DIGITS W/O PAIN. HAD MILD TENDER IN ANATOMIC SNUFF BOX." (PX 2)

Dr. Pye's "Assessments" includes the following: "Other wrist sprain and strain." (PX 2)

On May 9, 2012, at U.S. Rehabilitation, Petitioner reported all of his surgeries: "Left & right shoulder – Rgt. Knee – left hip – left wrist." Physical Therapist Ellen O'Donnell noted, with regard to Petitioner's right wrist, that there was bruising and swelling over the radial styloid process, and that flexion and extension was to 35°. (PX 3)

On May 14, 2012, Ellen O'Donnell, PT, noted decreased swelling and bruising around the radial side of the wrist. (PX 3)

On May 23, Ellen O'Donnell, PT, wrote: "No complaints of pain in R wrist or elbow." (PX 3)

Dr. Pye did not document any complaints by Petitioner to right hand/wrist at his visits to Dr. Pye on May 16, 17, 21, 23, and 31, 2012.

On June 5, 2012, Petitioner made no complaints of right hand/wrist pain to Dr. Pye. On this date, Dr. Pye recorded Petitioner's surgical history, which included "right thumb." (PX 2)

On July 9, 2012, Petitioner stated that pain in his right wrist is increased with pushing, pulling, and lifting of objects that weigh more than 10 lbs. He also stated that pain in his right wrist is 5/10 and does not appear to improve with rest or meds. (PX 2)

X-rays of Petitioner's right wrist/hand were taken on July 16, 2012, and were found to be "Unremarkable." (PX 2)

On July 20, 2012, Petitioner told Dr. Pye that the injury to his right wrist and hand has pretty much resolved. (PX 2)

On August 3, 2012, Petitioner reported 2/10 wrist pain at that time and only with twisting, turning, pushing, or pulling objects. Upon examining Petitioner's wrist, Dr. Pye found the following: INSPECTION: negative swelling. PALPATION (SOFT TISSUE): no tenderness TFCC, FCR, ECU, 1st DC. ROM: full ROM. STRENGTH: full grip. STABILITY: no instability. SENSATION: L.T. sensation intact all fingers. VASCULAR: normal pulses." (PX 2)

On August 20 and 28, and September 4, 2012, there are no documented complaints of right wrist pain. (PX 2)

On September 20, 2012, Petitioner reported 2/10 wrist pain at that time and only with twisting, turning, pushing, or pulling objects. Upon examining Petitioner's wrist, Dr. Pye found the following: INSPECTION: negative swelling. PALPATION (SOFT TISSUE): no tenderness TFCC, FCR, ECU, 1st DC. ROM: full ROM. STRENGTH: full grip. STABILITY: no instability. SENSATION: L.T. sensation intact all fingers. VASCULAR: normal pulses." Although Dr. Pye includes in his ASSESSMENTS, "Sprain and strain of unspecified site of wrist," his partner does not include a right hand or wrist problem among the diagnoses in the September 20, 2012 CITY OF CHICAGO WORK STATUS REPORT. (PX 2)

On October 18, 2012, Jim Holway, PT, included in his Assessment the following: "Sprain and strain of unspecified site of wrist." (PX 3)

The Arbitrator notes that in Dr. Pye's subsequent records in evidence there are either no documented complaints of right hand/wrist pain, or Dr. Pye does not evaluate this body part. Petitioner's Exhibit 2 indicates that Dr. Pye regularly treated Petitioner through November 21, 2013. (PX 2)

On a referral from Dr. Pye, Petitioner began treating for his low back with Dr. Slack on August 22, 2012.

The Arbitrator has carefully reviewed all the medical records, including Dr. Slack's records, and finds that after Physical Therapist Jim Holway's October 18, 2012 Assessment that

included sprain and strain of an unspecified site of the wrist, the next documented complaint of hand or wrist pain by Petitioner is on March 13, 2015, which was nearly 2½ years later. (PX 4)

In a REFERRAL LETTER, dated March 13, 2015, from hand surgeon Michael Jablon, M.D., back to Dr. Slack, Dr. Jablon wrote, in pertinent part, the following:

> "I had the pleasure of seeing Mr. Thomas Johnson today. He is a 59-year-old hoisting engineer who presents for evaluation of her (sic) right hand, thumb, and wrist injury. He noted that on May 4, 2012, he fell at work when twisting out of machine and his right thumb "popped out of place" and he has had significant pain at the base of his thumb with disuse subsequently. He also has had many issues with his back over the years as well as hip surgery associated with work injuries. He notes a sharp, aching, burning quality to pain of severe intensity which is constant, worse during and after activity and worsening. Repetitive motion, fatigue and gripping aggravates it and cold sometimes helps. Intake information includes he is right-hand dominant. **** Axial torque grind test markedly reproduced pain and was quite sensitive. He has a serpentine scar over the dorsum of his right first metacarpal and proximal phalanx consistent with previous surgery at the MCP level. **** X-rays … reveal CMC trapeziometacarpal joint osteoarthritis with deformation of the base of the right first metacarpal with small ossicle present. **** Eventually, he will be a candidate for ligament reconstruction, tendon interposition arthroplasty." (PX 4)

The Arbitrator notes that this is the first time since the accident that Petitioner gave a history that his thumb "popped out of place" when he fell. Yet, this was Petitioner's first visit to a hand specialist. Moreover, it appears that Petitioner's history of his thumb popping out of

place when he fell is supported by the findings of Dr. Pye and Physical Therapist O'Donnell. Four days after the accident, Dr. Pye found mild tenderness in Petitioner's right anatomical snuffbox, and one week after the accident, Ms. O'Donnell observed swelling and bruising over his right radial styloid process and found flexion and extension of the wrist limited to 35°.

On September 20, 2012, which was 6½ months after the accident, Petitioner reported 2/10 wrist pain and only with twisting, turning, pushing, or pulling objects. As of October 18, 2012, Jim Holway, PT, included in his Assessment the following: "Sprain and strain of unspecified site of wrist." In 2013 and 2014, Petitioner turned his attention to treatment for the more serious injuries to his low back and right hip.

Respondent did not have Petitioner examined by a Section 12 physician for his right hand/wrist and has no causation opinion to refute Petitioner's claim for the right hand/wrist injury. Moreover. Respondent denied all medical bills for treatment related to Petitioner's right hand/wrist.

Therefore, notwithstanding the nearly 2½-year gap in documented complaints, the Arbitrator finds that Petitioner has met his burden of proof that Petitioner's current condition of ill-being of his right hand/wrist is causally related to the accident.

With regard to Petitioner's right knee, the Arbitrator finds that his condition of ill-being is causally related to the May 3, 2012 accident.

Petitioner's testimony about the accident does not include any mention of striking or twisting his right knee. He testified that he tried to break the fall with his right hand and that he "kind of popped [his] hand back and landed on [his] elbow and [his] hip." (Tr. 12-13)

Furthermore, when he completed the "Report of Occupational Injury or Illness" on May 3, 2012, he made no mention of a right knee injury. There is no evidence that Petitioner specifically complained about his right knee to Dr. Bartolome on May 3, 2012 or to Dr. Pye on May 7, 2017. Dr. Pye examined Petitioner's right knee when he conducted a general examination, and noted the following:

> "RT KNEE: POST LATERAL JOINT LINE TEND. POST TENDER OVER PROXIMAL FIBULAR HEAD. POS TENDERNESS OVER HAMSTRING TENDONS. POS TENDERNESS OVER COLLATERAL LIGAMENTS. NEG SWELLING WAS NOTED. POS TEND OVER PATELLAR TO PAL-PATIO (sic) AROM 1-140. NEG LACHMAN, NEG PIVOT, NEG APLEY NEG McMURRAY, POSITIVE PATERLLAR (sic) COMPRESSION TEST." (PX 2)

Dr. Pye's May 7, 2012 assessment included a contusion of the knee. (PX 2)

On May 9, 2012, Petitioner's main complaint to Physical Therapist Ellen O'Donnell is as follows: "Lower back and his – leg pain in butt down to knee." Petitioner listed all of his surgeries: "Left & right shoulder – Rgt. Knee – left hip – left wrist." (PX 3)

When Dr. Pye examined Petitioner on June 5, 2012, he made no specific mention of right knee pain. At this time, Dr. Pye wrote: "**Surgical History:** left hip replacement, right thumb, right knee, right shoulder, left shoulder." (PX 2)

As of July 9, 2012, Petitioner voiced no complaints of right knee pain. (PX 2)

On September 6, 2012, Jim Holway, PT, includes the following in his Assessment: "Other unspecified derangement of medial meniscus." The Arbitrator deduces that as there had not been any recent complaints of right knee pain, this notation refers to Petitioner's prior right knee surgery.

On November 16, 2016, Petitioner underwent the following procedure: "Right hip anterior approach hip replacement with MAKOplasty robotic guidance, fluoroscopic supervision greater than one hour" at Munster Specialty Surgery Center. (PX 14)

On December 5, 2016, Petitioner was first evaluated by Colleen Dansart, PT, at ATI Physical Therapy. Ms. Dansart's Assessment included the following statement: "Pt. would benefit from skilled PT to improve hip ROM and LE strength as needed for normalized gait pattern and return to reciprocal stair climbing." (PX 15)

Petitioner reported to Physical Therapist Dansart on December 13, 2016 that his hip is feeling better and it is easier to bear weight on his right lower extremity. (PX 15)

Petitioner continued to treat with Ms. Dansart at ATI on December 22, 23, 27, 29, and 30, 2016. Petitioner also treated with her on January 3, 2017. (PX 15)

On January 5, 2017, Physical Therapist Dansart included the following statement in her Assessment: "Introduced 5 dead lifts demonstrating R knee pain with incr. depth in squat." (PX 15)

On January 6, 2017, Physical Therapist Dansart included the following statement in her Assessment: "Pt. remains limited w/performing squats due to decreased knee flex depth due to reports of R knee pain." (PX 15)

On January 12, 2017, Physical Therapist Dansart included the following statement in her Assessment: "Progressed DL & SL w/o incr. hip pain though demos poor eccentric control due to R knee pain. Completed 10# dead lifts with reports of mild R knee pain upon completion of ex." (PX 15)

On January 17, 2017, Physical Therapist Dansart included the following statement in her Progress Note: "Pt. reports receiving a cortisone shot yesterday on (sic) his right knee." (PX 15)

On January 17, 2017, Petitioner saw Dr. Gonzalez in follow up for his right thumb surgery. At that time, he reported that "his knee has been bothering him on the right side and mentions an old injury sustained during a fight in 1990, which has been acting up more recently." Upon examination, Dr. Gonzalez found that he has a full range of motion from 0° to 120°, stable to varus and valgus stress, but does have some laxity compared to the left side with Lachman's and anterior drawer. Stable posterior Drawer testing. Neurovascularly intact distally. In his assessment and plan, Dr. Gonzalez noted that "[t]his is a 61-year-old male who presents about 10 months status post right thumb LRTI, doing well and right knee pain, which has been acting up from an old injury in 1990, but bothering him more since his total hip replacement." (PX 4)

X-rays of the right knee taken on January 17, 2017 were interpreted as showing moderate degenerative joint disease. (PX 4)

On January 19, 2017, Colleen Dansart, PT, provided the following Assessment of Petitioner:

> "Bosu lunges initiated to address pt. balance on uneven surface and improve depth of hip flexor ROM. Pt had c/o R knee instability from incr. WBing on RLE during lunges but completed activity sufficiently. Attempted to address poor eccentric quad control through star excursion drill but pt. demo'd significant instability and buckling and exercise was discontinued." (PX 15)

On January 23, 2017, in her Discharge Summary, Physical Therapist Dansart stated, in pertinent part, the following: "Continues to report slight soreness with stair climbing and squatting though right knee pain also contributes to difficulty with these activities." (PX 15)

Petitioner testified that Dr. Gonzalez told him at that time to do some home exercises or physical therapy for the right knee, and if it does not respond, he was to get an MRI of the knee. Petitioner testified that Dr. Gonzalez did not write up a prescription for an MRI. Dr. Gonzalez's records make no mention of an MRI. (PX 4)

The evidence indicates that the activities Petitioner performed in physical therapy following his November 16, 2016 right hip replacement surgery aggravated the condition of his right knee.

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 independent intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury. National Freight Industries v. Illinois Workers' Comp. Comm'n, 993 N.E.2d 473, 373 Ill. Dec. 167 (5th Dist. 2013)

In the case at bar, there is no evidence of an intervening accident or injury.

Therefore, notwithstanding the fact that neither Dr. Gonzalez nor any other medical professional has offered a causation opinion, the Arbitrator finds that the current condition of ill-being of Petitioner's right knee is causally related to the May 3, 2012 accident.

In support of his decision with regard to issue (L) "What temporary benefits are in dispute? TTD," the Arbitrator finds as follows:

Petitioner claims that he has been temporarily totally disabled from May 4, 2012, the day after the accident, through May 23, 2017, the date of the arbitration hearing. (AX 1)

Respondent claims that Petitioner has been temporarily totally disabled from May 4, 2012, the day after the accident, through May 31, 2013.

Respondent has relied on the opinions of Dr. Levin and Dr. Troy.

Dr. Levin authored reports dated April 17, 2013 and May 10, 2013. Dr. Levin examined Petitioner for his hip, but not for his low back condition. In his second report, Dr. Levin opined that "MMI does not apply regarding an occurrence of May 3, 2012 to his right hip since it is my opinion that his symptoms are the result of underlying pathology that became symptomatic on that date and not an acute traumatic event to his right hip of that date." Dr. Levin concluded that Petitioner's right hip condition was not related to his fall at work on May 3, 2012. He noted that there were no acute changes in the MRI of July 16, 2012. (RX 3, Dep. Ex. 2)

Based upon that opinion, Respondent terminated temporary total disability benefits in spite of Petitioner's need for continuing treatment for his spine condition, for which Dr. Charles Slack provided treatment upon referral from Dr. Pye.

Dr. Troy authored a report dated January 16, 2014. Dr. Troy opined that Petitioner's non-Workers' Compensation related avascular necrosis brought about complaints of pain in the right hip and secondary complaints to his low back. He further opined that Petitioner can return to work at restricted duty for non-Workers' Compensation related causes. (RX 4, Dep. Ex. 2)

For the reasons stated above, the Arbitrator has found the opinions of Dr. Domb and Dr. Slack, the treating physicians, to be more persuasive than the opinions of Dr. Levin and Dr. Troy, the Section 12 examining physicians.

Petitioner was treated primarily by doctors selected by Respondent. This treatment commenced with MercyWorks on the date of accident, and then, for the most part, upon referral from that Respondent-designated clinic to Dr. Pye of HTP Associates. The medical records support Petitioner's entitlement to 8(b) benefits as claimed. In reviewing the treating records of Dr. Pye, Dr. Slack, Dr. Smith, Dr. Domb, and all of the other medical providers, the Arbitrator notes that the best any of them could recommend with regard to Petitioner's work status was a return to work with light-duty restrictions that Respondent could not or would not accommodate.

Based on the foregoing, the Arbitrator finds that Petitioner has been temporarily totally disabled from May 4, 2012 through May 23, 2017, and is therefore entitled to TTD benefits during that period. Petitioner agreed with Respondent's claim that they paid TTD benefits in the amount of $67,524.70 and an advance in the amount of $16,618.00, as well as ordinary disability benefits in the amount $186,582.00. Respondent is entitled to an 8(j) credit of $5,190.90. (AX 1)

The language of Section 7030.40 of the *Rules Governing Practice Before the Workers' Compensation Commission* indicates that the request for hearing is binding on the parties as to the claims made therein. Walker v. Indus. Comm'n, 804 N.E.2d 135, 281 Ill. Dec. 509 (4th Dist. 2004). The Arbitrator notes that when such *Rules* were amended, minor changes were made to Section 7030.40, and it became Section 9030.40 of the amended *Rules*.

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?," the Arbitrator finds as follows:

Petitioner offered, as Petitioner's Exhibit 17, a compendium of medical expenses totaling $279,000.34, which includes $752.40 for out-of-pocket payments by Petitioner.

The Arbitrator has found that there is a causal connection between the accidental injury of May 3, 2012 and the conditions of ill-being of Petitioner's low back, right hip, right hand/wrist, and right knee.

After reviewing all the medical records in evidence that detail the treatment rendered to Petitioner by the physicians, physical therapists, and other medical professionals, most of whom were the consequence of treatment by Respondent-referred doctors, the Arbitrator finds that such medical care was reasonable, necessary and related and awards Petitioner $279,000.34, which is a total of all unpaid medical bills (PX 17), pursuant to Section 8(a) and subject to Section 8.2 of the Act.

In support of his decision with regard to issue (M) "Should penalties or fees be imposed upon Respondent?," the Arbitrator finds as follows:

Petitioner requests the imposition of penalties pursuant to Sections 19(k) and 19(l), and the imposition of attorney's fees pursuant to Section 16 of the Act.

The Arbitrator finds that Respondent had bona fide disputes as to whether the current conditions of ill-being of Petitioner's right hip, right hand/wrist, and right knee are causally

related to his accident of May 3, 2012 in which he fell off the Vactor.

On April 17, 2013, Dr. Levin examined Petitioner's right hip on behalf of Respondent, and in a report dated May 10, 2013, opined that the right hip condition was not causally related to the May 3, 2012 accident. However, Dr. Levin did not examine Petitioner's low back and, therefore, did not render opinions on that body part.

Respondent paid TTD benefits from May 4, 2012 through May 31, 2013.

It was not until Dr. Troy examined Petitioner's low back and right hip on January 16, 2014, that any doctor opined that Petitioner's low back condition was not related to the May 3, 2012.

Dr. Slack did not give a formal causation opinion with regard to Petitioner's low back condition until July 3, 2014.

However, the Arbitrator finds that the medical records and the chain of events clearly support Petitioner's claim that his low back condition is causally related to the May 3, 2012 accident. When Dr. Slack first examined Petitioner on August 22, 2012, he found that Petitioner had persistent low back derangement with radicular symptoms and continued his temporary total disability status. Thereafter, Dr. Slack actively treated Petitioner for his low back condition. As of May 31, 2013, Dr. Slack had not lifted his light-duty restrictions for Petitioner, which consisted of no lifting of more than 10 pounds, and an avoidance of repetitive bending, twisting, and lifting.

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to 19(l) penalties of $30.00/day for 229 days, from June 1, 2013 through January 15, 2014.

In support of his decision with regard to issue (K) "Is Petitioner entitled to any prospective medical care?," the Arbitrator finds as follows:

Petitioner testified that he is doing home exercises for his hip and back and that he does not currently participate in any formal physical therapy regimen for his hip, but is to follow up with Dr. Domb in three months.

Petitioner testified that he is actively treating for his back, and is to see Dr. Slack after his last visit with Dr. Rabi.

Therefore, the Arbitrator finds that Petitioner is entitled to prospective medical care for his back with Dr. Slack and Dr. Rabi.

Petitioner is also entitled to the follow-up visit to Dr. Domb since his right total hip replacement took place on November 16, 2016.

As the Arbitrator has causally related Petitioner's right knee condition with the accident, he finds that Petitioner is entitled to prospective medical care for his right knee from Dr. Gonzalez. On January 17, 2017, Dr. Gonzalez recommended physical therapy for the right knee and instructed Petitioner to follow up with him when Petitioner returns from Florida. At that time, Dr. Gonzalez did not recommend further treatment for Petitioner's right hand/wrist, and released him to his normal activities for the hand/wrist.

Brian T. Cronin
Arbitrator

11-20-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ZINA RIOS,

Petitioner,

vs. NO: 10 WC 21755

TYSON FRESH MEATS, INC.,

Respondent.

18IWCC0544

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. A separate Decision has been issued for case number 11 WC 45991.

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.

Although this case on Review pertains to an accident that occurred on June 22, 2009, before the September 1, 2011 amendments to the Act, the Arbitrator proceeded to analyze the nature and extent of Petitioner's claim utilizing the five factors in Section 8.1b(b) of the Act. The Arbitrator awarded Petitioner 37.5% loss of use of the person as a whole; the basis of her award included the fact that Petitioner was 44-years-old at the time of the accident; and, after undergoing a right shoulder full-thickness supraspinatus tendon tear repair and right shoulder biceps tenodesis, she was released with permanent restrictions.

The Arbitrator further noted that Petitioner returned to her regular duties for Respondent as a supervisor. However, she was now assigned the second shift. In March 2014, Petitioner accepted a safety management position with Respondent; she received a raise. However, that position only lasted until July 2014 when Petitioner was terminated from that position due to a company-wide layoff. Petitioner was told to apply for another position in Nebraska but declined in consideration of her family. The Arbitrator found that Petitioner was able to continue working in her usual and customary line of employment with Respondent as a supervisor with permanent restrictions, but that Petitioner decided for personal reasons not to continue working for Respondent.

Based on the record in its entirety, the Commission finds that while the Arbitrator's Decision was well-reasoned, the PPD award was excessive. Although it appears that Respondent made it difficult for Petitioner to work in her capacity as a supervisor, Petitioner nevertheless did return to work for Respondent as a supervisor with no loss in earnings. The Commission further finds that Petitioner performed her duties for approximately two years and would have continued to do so had there been no layoff. There is no evidence in the record that Petitioner's injuries, as a result of the June 22, 2009 work accident, precluded her from her usual and customary line of employment as a supervisor.

In consideration of Petitioner's right shoulder injury, her need for a right shoulder full-thickness supraspinatus tendon tear repair and right shoulder biceps tenodesis, her release with permanent restrictions, and her ability to continue in her usual and customary line of employment, the Commission hereby reduces the Arbitrator's award and finds instead that Petitioner sustained 25% loss of use of the person as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.62 per week, for a period of 15 3/7 weeks, from November 13, 2009 through February 28, 2010, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.88 per week, for a period of 2 weeks, from March 1, 2010 through March 14, 2010, that being the period of temporary partial incapacity for work under Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $10,995.02 for TTD benefits, and $712.88 for temporary partial disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $641.36 per week for a period of 125 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 25% loss of use of the person as a whole.

18IWCC0544

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

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

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

DATED: SEP 5 - 2018

Michael J. Brennan

MJB/pm
D: 08-28-18
052

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

RIOS, ZINA
Employee/Petitioner

Case# **10WC021755**

11WC045991

TYSON FRESH MEATS INC
Employer/Respondent

18IWCC0544

On 5/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0222 GOLDBERG WEISMAN & CAIRO LTD
DANA N BLUMTHAL
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

2593 GANAN & SHAPIRO PC
PAUL D DYKSTRA
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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
CORRECTED ARBITRATION DECISION

ZINA RIOS,
Employee/Petitioner

v.

TYSON FRESH MEATS, INC.,
Employer/Respondent

Case # 10 WC 21755

Consolidated cases: 11 WC 45991

18IWCC0544

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Rock Island**, on **3/8/17**. 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 _____

FINDINGS

On **6/22/09 and 7/31/10**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

On 6/22/09, Petitioner *did* sustain an accident to her right shoulder that arose out of and in the course of employment.

On 7/31/10, Petitioner *did not* sustain an accident to her left shoulder that arose out of and in the course of employment.

Timely notice of the accidents *was* given to Respondent.

Petitioner's current condition of ill-being as it relates to her right shoulder *is* causally related to the accident on 6/22/09.

Petitioner's current condition of ill-being as it relates to her left shoulder *is not* causally related to the accident on 7/31/10.

In the year preceding the injury on 6/22/09 and 7/31/10, Petitioner earned **$53,446.25**; the average weekly wage was **$1,068.93**.

On 6/22/09, Petitioner was **44** years of age, ***married*** with **2** dependent children.

On 7/31/10, Petitioner was **45** years of age, ***married*** with **2** dependent children.

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

Respondent ***has or will*** pay all appropriate charges for all reasonable and necessary medical services for the right shoulder. Respondent will not pay any charges for medical services for the left shoulder.

Respondent shall be given a credit of **$10,995.02** for TTD for the right shoulder, **$712.88** for TPD for the right shoulder, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$11,707.90**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $712.62/week commencing 11/13/09 through 2/28/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits totaling $712.88 for the period 3/1/10 through 3/14/10, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $641.36/week for 187.5 weeks, because the injuries sustained caused the 37.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

5/5/17
Date

ICArbDec p. 2

MAY 8 - 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 44 year old supervisor, sustained an accidental injury that arose out of and in the course of her employment by respondent on 6/22/09 (10 WC 21755). On this day petitioner injured her right shoulder while picking up pieces of intestines and putting them into barrels. This case was heard in consolidation with case 11 WC 45991 (11 WC 45991) which involves an alleged overuse of the left arm due to petitioner's injury to her right arm. The alleged accident date for that case is 7/31/10.

Petitioner worked for respondent from 1994 to 2014. Petitioner began as a team member on the floor. She worked in Quality Assurance for 5 1/2 years. She was then a Sanitation Supervisor for 3 1/2 years. She was then a Production Supervisor in the pork division, and then worked in the Sales Department to learn the beef side of the business. After that petitioner worked on the A shift as a training supervisor to further her education in the beef side of the business.

Petitioner testified that she injured her right shoulder while working in the beef division. She stated that her job was to set up the line for team members. She would teach them the specifications of the product and the meat schedule.

Petitioner graduated from American Intercontinental University in 2009. In 2012 she got her Masters Degree in Business Administration and Human Resources. Petitioner currently works at Lujack Auto Plaza as a sales consultant. She has worked there for about 1 1/2 years. Her current duties are helping people find cars and online chats.

Petitioner testified that on 6/22/09 she was sent to the rendering area, an area where she had never been before. She testified that there were cow intestines up to her knees. She testified that she had to put on a rubber suit and put the intestines into a barrel, and then pull the barrel along the assembly line. She stated that the product weighed 100 pounds. She testified that she and other managers were called in to perform this job. Later in her testimony she stated that was performing these duties on a regular basis when the belts were not working.

When petitioner got home she went into her Jacuzzi. She testified that it was then that she noticed a bone sticking out of her right shoulder. She testified that she called her supervisor, Aaron Johnson, on his cell phone.

Petitioner testified that she was not sent to Concentra until 2 months after the injury. However, the medical records show that on 6/22/09 she presented to Dr. Eugene Gaertner at Concentra Medical Centers. She reported an injury to her right shoulder while working for respondent on 6/22/09. She stated "I am not sure what exactly hurt my shoulder at work". She reported that the pain began gradually. The pain was located on the acromioclavicular joint of the right shoulder and lateral aspect of the right shoulder. She stated that she

experienced no pain initially. She rated her pain at a 1/10. She noted that the pain radiated to the right arm. An x-ray of the right shoulder was negative. She had full range of motion, and normal rotator cuff motion. No tenderness was present, but swelling was noted at the AC joint. She was assessed with an acromioclavicular strain. Petitioner was released to work with no restrictions.

On 6/30/09 petitioner presented to Dr. Dunbar at Concentra Medical Centers. She reported that she did not have problems except local pain until a self examination revealed a bony prominence over the right AC joint. She was concerned that she had dislocated her shoulder. She complained of occasional discomfort and some diffuse weakness over the upper arm. Petitioner demonstrated some weakness with drop arm test and discomfort with performance of scapcion, and radiation of discomfort to the lateral upper arm with resisted abduction. Petitioner was assessed with a history of a right shoulder contusion, and bony prominence with no abnormalities. X-rays of the acromioclavicular joints with and without weights were normal. Physical therapy was ordered.

Petitioner began a course of physical therapy on 7/1/09 at Rock Valley Physical Therapy. She attributed her symptoms to shoveling of product.

On 7/13/09 petitioner returned to Dr. Gaertner and reported that she had no improvement with physical therapy. However when Dr. Gaertner reviewed the therapy records it was noted that she had approximately a 90% improvement and achievement of the initial goals. She stated that she was working her regular duty job. She reported that she no longer had any significant pain and felt that her function was near normal. She had no radiating pain. Following an examination, petitioner was assessed with shoulder strain-trapezius/rhomboid. Additional physical therapy was recommended and petitioner was released to full duty work.

On 8/10/09 petitioner reported very minimal pain in her right shoulder. She continued to be unhappy about the fact that she had asymmetry of her AC joints. She reported discomfort when she laid on her right side. The therapist examined petitioner and noted complaints of pain, fairly minimal. Petitioner's motion and strength were within normal limits.

On 8/13/09 petitioner followed-up with Dr. Gaertner. Petitioner reported an improvement in her functional status with physical therapy. Petitioner reported that she had minimal pain, but was much better overall, with near normal function. She rated her pain at a 1/10, exacerbated by raising her arms overhead. Petitioner was examined and assessed with acromioclavicular bursitis and shoulder impingement. Petitioner was referred to Dr. Brozovich.

On 9/2/09 petitioner presented to Dr. Brozovich. She gave a history of helping to move a large rolling tub filled with meat products on 6/22/09. She reported a right shoulder injury. Dr. Brozovich was of the opinion that the right acromioclavicular joint was intact. He believed her acromioclavicular joint appeared elevated because she was carrying her right shoulder slightly elevated. Dr. Brozovich diagnosed a possible labral tear.

On 9/2/09 petitioner returned to Dr. Dunbar complaining of deep right shoulder discomfort. She reported pain when she rolls on it or is asked to pull objects from a lower level at work. Dr. Dunbar reviewed petitioner's history of injury and that her pain complaints did not occur until she began physical therapy. Petitioner admittedly agreed. Petitioner stated that she was continuing in her regular duty job and it was not problematic. An MRI arthrogram was ordered. Dr. Dunbar canceled any further chiropractic care. A home exercise program was prescribed. She was released to regular duty.

On 9/14/09 petitioner underwent an MR arthrogram of the right shoulder. The impression was full-thickness tear anterior supraspinatus tendon with partial-thickness undersurface tear of the remainder of the supraspinatus tendon.

Petitioner returned to Dr. Dunbar on 9/18/09, post MRI. Petitioner reported that she was still working her regular job and only had discomfort with certain maneuvers. Dr. Dunbar reviewed the MR arthrogram and assessed a right rotator cuff tear. Dr. Dunbar was of the opinion that petitioner was a surgical candidate and needed to see an orthopedist. Petitioner was not given any restrictions.

On 9/23/09 petitioner presented to Dr. Tuvi Mendel for an orthopedic evaluation. Following an assessment, Dr. Mendel assessed an acute right sided rotator cuff tear. He recommended a shoulder scope, decompression, possible AC joint resection with rotator cuff repair in the near future.

On 11/9/09 petitioner presented to Dr. Sanchez-Sotelo at Mayo Clinic on a self referral for a second opinion regarding her right shoulder. Petitioner gave a consistent history of the accident. She stated that same day after she went home and got into her hot tub she noticed deformity and prominence of the lateral end of the clavicle. She felt some discomfort over the next few weeks, but her symptoms continued to become worse despite physical therapy. Her main complaint was pain at a 4/10 most of the time and an 8 to 9/10 at its worst. Following an examination Dr. Sanchez-Sotelo's impression and diagnosis was right shoulder combined subscapularis full-thickness supraspinatus partial-thickness articular-sided tear.

On 11/11/09 Dr. Sanchez-Sotelo drafted a letter to respondent's claim adjuster. He was of the opinion that it is possible to develop a full-thickness tear from a one-day event, even though he suspected that she probably had some pre-existing deterioration of the tendon that facilitated this injury. He was further of the opinion that

the mechanism of injury described by petitioner may explain an extension of a previous rotator cuff tear. He was of the opinion that it is difficult to determine if petitioner's shoulder injury is the direct result of the 6/19/09 work injury. He believed that if petitioner developed an extension of a previously-compromised tendon during her injury on 6/19/09, it would require the recommended surgery. He was also of the opinion that her shoulder condition may have been aggravated by the 6/19/09 lifting, and the aggravation had not yet resolved.

On 11/13/09 petitioner underwent a right shoulder full thickness supraspinatus tendon tear repair, and right shoulder biceps tenodesis. The post-operative diagnosis was right shoulder rotator cuff tear with associated biceps tendinopathy. Petitioner followed-up post-operatively with Dr. Sanchez-Sotelo. Post-operatively petitioner also underwent physical therapy at Rock Island Physical Therapy from 2/22/10-5/6/10. Petitioner followed-up post-operatively with Dr. Sanchez-Sotelo.

On 2/15/10 Dr. Sanchez-Sotelo released petitioner to work on 3/1/10 part-time for two weeks. He was of the opinion that she would return to work with the understanding that she would not be using the right upper extremity at work. On 4/18/10 petitioner followed up with Dr. Sanchez. Dr. Sanchez gave petitioner restrictions that included lifting no greater than 25 pounds in the right hand.

On 5/6/10 petitioner reported to her physical therapist that the swelling in her arm started to decrease, especially in the last 2 days. Petitioner's main complaint was scrubbing her back in the shower and reaching overhead to put things on a shelf. Petitioner reported that there were a lot of exercises that she could do at home. The therapist noted that petitioner's active shoulder range of motion was improved in flexion and abduction compared to her last treatment series. Petitioner demonstrated improved scapulohumeral rhythm and decreased shoulder hike. Petitioner seemed to have benefitted from a temporary decrease of the strengthening component of rehab for pain modulation and swelling. Petitioner was taped to reposition the humeral head and decrease activation of the upper trap at the end of the treatment.

On 5/18/10 Dr. Sanchez-Sotelo noted that he would like to see here again in November to determine her residual stiffness and that would likely translate into some permanent partial disability. In the meantime, he was of the opinion that petitioner could return to work with the ability now to lift up to 25 pounds of weight. He was of the opinion that petitioner could perform repetitive motion, and work 12 hour shifts. He believed she would benefit from continued physical therapy.

On 5/25/10 petitioner resumed physical therapy at Rock Island Physical Therapy. Petitioner reported that she returned to full duty/full time work for respondent as a manager in the packaging department. Petitioner reported that she spends about 75% of her time completing supervisory roles and the remaining 20% on the line.

If petitioner has to work on the line she may have to pick up product from the floor, and place it in a component requiring her to reach over at the waist level, and transferring product from the lines into boxes. She reported that this may require a lot of twisting motion, mainly to the right. She reported that the max amount of weight she would lift from the floor could be up to 90 pounds. She stated that any overhead reach would be rare and not over 30 pounds. Petitioner stated that she works a 12 hour shift.

Petitioner testified that respondent honored her restrictions until the tape came off her right hand/arm. She stated that after her surgery when she returned to work there was new machinery in the area. She testified that she only used her left arm to throw product off the line and clean off machines. Petitioner testified that when the machine broke down someone was supposed to come in and help, but they did not, and on several occasions when it broke the product piled up. Petitioner testified that on the occasions when the machine broke she would use her left hand to throw the product off the belt and rinse the belt off with a 180 pound fire hose. Petitioner testified that she would pull the 180 pound fire hose with her left hand. She testified that she was only supposed to do a supervisory job.

Despite these reported complaints at trial, on 7/8/10 petitioner reported to her therapist that things were going very well. She stated her arm/shoulder did not limit her much anymore. She stated that her biggest restrictions were with respect to her recreational activities. She reported difficulties throwing a ball, shooting a basketball, and dribbling a basketball. She noted that her perceived improvement was 80%.

On 8/6/10 petitioner notified Dr. Sanchez-Sotelo that she had complaints of increasing pain in the left shoulder without any significant history of injury. She said it had been present for only the last week. She reported that her left shoulder was painful when she lifts the shoulder, particularly when she is doing her hair. She requested that she see Dr. Sanchez-Sotelo as soon as possible.

On 8/9/10 petitioner drafted a note to "To Whom It May Concern". She wrote "Last Saturday July 31, 2010, I was at home brushing my hair and immediately when I went up to brush my hair again my arm wouldn't go pass my shoulder. This lasted about 10-15 min, that I couldn't extend my left arm up. Friday, August 07, 2010 I was getting ready to go into therapy and went to put my hair up and once again my arm wouldn't extend pass my shoulder. Both times it left me in a great deal of pain, but a couple days later, I felt nothing. This is really bothering me. I asked for left arm to be evaluated because I definitely don't want to go through what I had to go through with arm (right)." Petitioner signed the note.

On 8/9/10 petitioner completed an Employee Injury/Illness Statement. She described her injury as "can't use (L) arm pass (sic) the shoulder occasionally". In response to what she thought caused her problem she wrote

"not use to using left arm had surgery on the right (right handed)". Where asked what she was doing when she first noticed the problem she wrote "brushing her hair". She identified the date of injury as 7/31/10. She noted that the injury was work related and that she told her supervisor. However, she did not indicate which supervisor she reported this to, or when she reported this to her supervisor. In response to any aspects of her job which she thought was causing or aggravating her condition, she wrote " No use of right arm for several mths, or possibly injured when right arm, not sure".

At trial petitioner testified that she first claimed a specific injury to her left shoulder, and then reported that she hurt her left shoulder due to overuse because she could not use her right shoulder. She testified that she used her left arm for everything when she could not use her right shoulder. Petitioner testified that her bone jarred when she went brush her hair and that caused her pain. Petitioner testified that her right shoulder was worse after surgery than it was before.

On 8/25/10 petitioner underwent an MRI of the left shoulder. The impression was a nearly 1-cm loose body, likely resulting in the limited range of motion. It was noted that there was either a severe partial tear or a full-thickness tear involving the supraspinatus, and there was extensive tendinopathy or a partial tear involving the infraspinatus and subscapularis. A SLAP tear of the labrum was suspected. Also noted was a probable low grade cartilaginous lesion in the humerous. Plain film correlation was recommended to confirm a calcified loose body as well as to evaluate the proximal humeral lesion.

On 9/7/10 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that he reviewed the MRI of her left shoulder. He was of the opinion that it showed a tendon tear in the left shoulder as well as maybe a ligament injury in the labrum. He was of the opinion that these tears may benefit from surgery depending on how she responds to steroid injections and physical therapy.

On 9/20/10 Dr. Sanchez-Sotelo noted that petitioner's right shoulder seemed to be doing quite well. He noted that she had no problems with the left shoulder until she woke up one morning with a spontaneous episode of acute shoulder pain that lasted for about 24 hours, and then the pain went away completely. She reported a 2nd episode like that, that also improved. Dr. Sanchez-Sotelo noted that petitioner's x-ray of the left shoulder showed a lesion on the upper third of the humeral shaft consistent with an enchondroma. He noted that the MRI showed tendinopathy affecting the supraspinatus and subscapularis tendons as well as some thickening around the biceps tendon and the labrum. His impression was left shoulder pain consistent with labral versus biceps pathology versus supraspinatus tendinopathy, and possible left humerus enchondroma versus low-grade malignant chondral tumor. Dr. Wegner did not think the lesion had the characteristics of malignancy right now, but was of the opinion that the lesion needed follow-up.

On 11/22/10 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that her right shoulder was completely healed and she did not have permanent restrictions in terms of lifting.

On 1/3/11 petitioner returned to Dr. Sanchez-Sotelo for follow-up of her right shoulder. She complained of difficulty with both shoulders. She stated that she was lifting up to 25 pounds at work. She stated that she was told she is expected to lift between 60 and 100 pounds. He did not think she could lift that in the future. A repeat MRI of the right shoulder showed her previous repair was healed, but she had tendinopathy of the supraspinatus and it looked like the deeper portion of the supraspinatus had retracted to the level of the midportion of the humeral head. Dr. Sanchez-Sotelo's diagnosis was persistent pain with a previous subscapularis/supraspinatus repair with evidence of a partial recurrence of the supraspinatus tearing on the articular side of the joint.

On 1/25/11 petitioner resumed physical therapy at Rock Valley Physical Therapy. She reported that after returning to work full duty she "wasn't using my arm because afraid was going to hurt it". She started to report pain, aching, and tingling throughout her right upper extremity. She reported that she spends approximately 20% of her day on the line reaching, pulling, transferring product from the line into boxes. She states that the max lift could be up to 100 pounds floor to waist, but infrequently. She stated that the max waist to overhead would be up to 30 pounds.

On 3/4/11 petitioner was discharged from physical therapy. Her overall condition was seen as "improving". The therapist was of the opinion that petitioner exhibited a fair prognosis at time of discharge from skilled rehabilitative therapy in conjunction with a home exercise. The therapist noted that the petitioner was independent in her home exercise program. Her current pain level was 6/10. Her functional tests showed floor to waist max lift of 50 pounds, and overhead max lift with right hand was 25 pounds, and max lift with left hand was 30 pounds. Her flexion on left was 160 to 150 degrees on right, and abduction was 150 on left and 130 on right. Petitioner had increased symptoms with horizontal abduction test.

On 3/8/11 petitioner underwent a repeat MRI of the left shoulder that showed that her tendinopathy had continued to improve. An FCE was prescribed.

On 3/29/11 and 3/30/11 petitioner underwent a Functional Capacity Evaluation (FCE). A formal job comparison could not be completed since a job description was not available for her position. She reported that even though her primary responsibility is being a manager, if the line breaks down she must help with much of the manual labor, which could require 60-100 pounds of weight handling. It was noted that petitioner's physical abilities would not match the requirement of 60-100 pounds of weight lifting. Petitioner demonstrated the

ability to statically push 70 pounds and pull 80 pounds; ability to lift floor to waist 20 pounds, occasionally (heavy level); ability to lift overhead up to 15 pounds, occasionally (heavy level); ability to carry up to 20 pounds, occasionally (heavy level); ability to carry with the right upper extremity up to 15 pounds, occasionally (heavy level); ability to carry with the left upper extremity up to 20 pounds, occasionally (heavy level).

On 4/5/11 Dr. Sanchez-Sotelo drafted a letter to petitioner after she called him trying to obtain a letter that would state she could not drive because of her chronic use of Vicodin. Dr. Sanchez-Sotelo was of the opinion that he did not believe that her shoulders justified continued use of Vicodin.

On 4/12/11 petitioner completed a Leave of Absence Application requesting a leave from 4/4/11 through 4/30/11 for a medical leave that was non-work related. Petitioner extended this leave to 5/2/11, 5/26/11, 6/10/11, 7/28/11, 8/11/11, 11/25/11, 12/6/11, 4/4/12, and 4/16/12. On cross-examination petitioner denied that she signed them. She testified that these forms were for her left shoulder. She stated that she was on a lot of medication at the time and did not understand the form and the fact that she checked on the form that the injury was not work related. On cross-examination she testified that she was told to sign it or she would be terminated.

On 4/18/11 petitioner underwent an MR arthrogram of the left shoulder. The findings were similar to the findings on 8/25/10. There was an approximately 1 cm loose body in the anterior subacromial-subdeltoid bursa that could be the result of a full-thickness tear which allowed a piece of synovium to enter into subacromial bursa and then enlarge. It was noted that this loose body could be having some mass effect and restricting range of motion. Also noted was a focal full-thickness tear of the far anterior distal inserting fibers of the supraspinatus tendon, and stable, and likely low-grade chnodroid lesion of the proximal left humeral diaphysis.

On 4/26/11 and 5/10/11 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that he could not envision any further treatment that would help her right shoulder.

On 5/12/11 petitioner presented to Dr. Scott Collins for her left shoulder. She identified the onset of her problem as 7/31/10 with no specific injury. She noted that her left shoulder pain was caused from over use of that arm due to surgery on the right shoulder 4 months ago. Petitioner reported sharp pain in her left shoulder that radiates up and down her arm. She noted that her left hand swells. She complained of lifting 30 pounds or more a lot at work. She also described constant pain in her neck, shoulder and back lifting product from 30 pounds to 50+ pounds every day, pulling product out of combos, or stacking on pallets. Dr. Collins assessed left shoulder pain. He recommended a left shoulder arthroscopy with debridement and chromioplasty. X-rays of the left shoulder demonstrated some degenerative changes of the left shoulder with some hooking of the acromion,

mild acromioclavicular. A chip of the bone was possible. Dr. Collins thought it was calcific tendinosis, that appeared to be an enchrondroma in her proximal humerus.

On 5/21/11 Dr. Sanchez-Sotelo signed a form indicating that she was at maximum medical improvement for her right shoulder with permanent work restrictions as determined by the FCE.

On 7/27/11 petitioner underwent a left shoulder arthroscopy, anterior labral tear repair arthroscopically, debridement, mini open rotator cuff repair, removal of loose body from the subacromial space, acromioplasty, rotator cuff repair, and removal of spurs on the acromioclavicular joint. The post-operative diagnosis was foreign body, rotator cuff tear, degenerative changes in the left shoulder and acromial hooking. This surgery was performed by Dr. Collins. Petitioner followed up post-operatively with Dr. Collins. The treatment included physical therapy. Petitioner was authorized off work.

On 8/16/11 Dr. Collins completed an Initial Claim Report for Disability Insurance for CUNA Mutual Group. The date the disability began was on 7/27/11, and her symptoms began on 7/31/10 while stocking product on pallets.

On 9/30/11 petitioner returned to physical therapy at Rock Valley Physical Therapy. She stated that while working full duty in early 2011 her left shoulder started to hurt. Petitioner reported that she took the medicine she was using for her right shoulder for her left shoulder. However, when she got off medication for right shoulder to do her final deposition on her right shoulder, her pain in her left shoulder increased significantly.

On 12/13/11 petitioner underwent an MRI of the cervical spine due to neck pain with radiation to the left shoulder. The impression was mild diffuse disk bulging most prominently at the C4-C5 level. No central spinal stenosis or focally herniated disk. There was no evidence of left neural foraminal stenosis to account for petitioner's left-sided symptoms.

On 12/20/11 petitioner told Dr. Collins that she was still having left shoulder pain as well as tingling and sharp pain that shoots down to the dorsal aspect of her left hand. She stated that it comes and goes, and was an 8/10 in severity. Dr. Collins impression was status post left shoulder arthroscopy, debridement, acromioplasty, distal clavicle excision, with open rotator cuff repair and removal of loose body, and left arm paresthesias. An EMG/NCV was ordered.

On 12/30/11 Dr. Robert Chesser performed an EMG/NCV, for her complaints of left upper extremity pain. She reported pain in her left scapular region that extends into the left arm and at times numbness in the left hand. Dr. Chesser noted somewhat limited cervical active range of motion in all planes; moving rather guardedly; complaint of pain in the left upper trapezius with forward flexion; increased pain with extension and

left rotation; and complaints of pain into the right upper trapezius with right rotation. The electrodiagnostic testing was normal. No entrapment of the median nerve or the ulnar nerve was confirmed.

On 1/6/12 petitioner reported to Dr. Collins that she was doing somewhat better. She complained of some left shoulder pain, as well as numbness and tingling that shoots down to the dorsal aspect of the left hand. She reported that the paresthesias was intermittent. Dr. Collins had no medical explanation as to why petitioner was experiencing the paresthesias of the left arm. He recommended that she continue activities as tolerated. Dr. Collins released petitioner to full duty work without restrictions.

On 1/17/12 petitioner was discharged from physical therapy for her left shoulder. Petitioner demonstrated a good prognosis from skilled rehabilitative therapy in conjunction with a home exercise program. Petitioner's pain was 2/10. She was found capable of working full duty unrestricted work. Her left arm flexion was 150, her abduction was 120 and her external rotation was 50 degrees. Her musculoskeletal improvement in her left shoulder showed muscle strength within normal limits.

Petitioner testified that when she was released to full duty work following treatment for her left shoulder she was placed on the B shift (evening shift). She worked from 2:30 pm to 2:00 am. She testified that she had been working the A shift because her daughter had seizures, and when working the second shift she did not see her kids. Petitioner testified that her duties on the 2nd shift were the same as those she had on the 1st shift. Since petitioner did not like working the 2nd shift she testified that she put in for jobs in other departments. As a supervisor petitioner's job was to make sure team members knew specifics of products, make sure orders were met, make sure yields were there, hold safety meetings, and ensure quality for the customers.

Petitioner testified that when she was released to full duty after her left shoulder surgery respondent was not honoring her lifting restrictions for her right arm. She testified that she was a packaging supervisor and when the belts and conveyors broke down she would have to throw the product into a big box. She testified that all this product weighed more than 20 pounds, and some weighed 100 pounds. She testified that she made complaints to her supervisors that she was not working within her restrictions, but did not provide any of the names of the supervisors or when she reported these complaints.

Petitioner testified that because she was working outside her restrictions on a constant basis when the conveyors shut down she started looking for a new position with respondent. She testified that the job she was doing was tearing up her body. She testified that she applied for 100 jobs. Petitioner ultimately was transferred to a Safety Management Position in Wisconsin in March of 2014. Petitioner earned more in this position. She testified that it was approximately $2000 more a year. In this position, petitioner had to travel to Arkansas for

training. She testified that she had no computer access, and put in a work order to have her computer problems fixed. Petitioner remained in this position until July of 2014. On 7/14/14 petitioner was placed on a permanent layoff from the Jefferson Plant in Jefferson, WI. Petitioner testified that other jobs were also being eliminated at that time in Wisconsin. She testified that her Safety Manager was transferred to Chicago, and others were transferred to other new positions in different locations. Petitioner was told to apply for a position in Nebraska. Petitioner did not apply for this position at the recommendation of her attorney and her husband. She also testified that she did not apply for the job in Nebraska because of the way respondent treated her. She testified that her husband told he would not move because of the way respondent treated her. Petitioner testified that she applied for 50 jobs including three Human Resource positions, but did not get any. She never did apply for the position in Nebraska.

Petitioner then looked for a job on her own. Petitioner offered into evidence Job Search Logs that contained 52 contacts from 7/14/14 through 4/7/15. From 7/14/14 through 1/14/15 petitioner applied only for jobs within Tyson. During this period she applied for 24 jobs with respondent. From 8/5/14 through 4/7/15 petitioner applied for 28 jobs outside Tyson, some as far away as Pennsylvania and New Jersey. She testified that she ultimately got the job with LuJack about August 2015.

Petitioner offered into evidence paychecks from 10/13/16 through 1/13/17 from LuJack's. For the period 10/16/16-10/31/16 petitioner earned $833.33 in salary. For the period 10/1/16-10/31/16 petitioner earned $1,411.40 in sales commission. For the period 11/1/16-11/15/16, 11/16/16-11/30/16, 12/1/16-12/15/16, 12/16/16-12/30/16, and 1/1/17-1/15/17 petitioner earned $833.33 in salary each period. For the period 12/1/16-12/1/16 petitioner earned $575.00 for Var Contest. For period 11/1/16-11/30/16 petitioner earned $1,770.39 in sales commission. For the period 12/1/16 through 12/31/16 petitioner earned $1,937.03 in commission.

Petitioner testified that she made $44,000 last year working for Lujack. She further testified that she earned more than $65,000-$68,000 working for respondent. She agreed that she made $53,000 on the date of accident.

Currently, petitioner has difficulty doing activities with her daughter that include softball and basketball. She also reported difficulty with normal housework and yard work, sleeping at night, and dressing herself.

Petitioner testified that while she was off work for her left shoulder she did receive short term disability benefits for her time off.

Courtney Davis, occupational health nurse for respondent from 2008 through June of 2011, was called as a witness by petitioner. Davis' duties included working with employees with work related injuries. Davis testified

that petitioner was originally seen by another nurse, but as she was looking at petitioner she notice a bulge from her clavicle area and immediately completed the paperwork to send her to Dr. Dunbar. She testified that she told petitioner there was nothing she could do for her. Davis testified that she makes sure employees restrictions are accommodated. However, she stated that while walking the floors one day, she saw petitioner tugging a vat of meat and reported it to her supervisor. She stated that petitioner was brought in and told her restrictions would be accommodated. She stated that petitioner was put somewhere else for that day. She testified that she knew of 5 occasions where petitioner's restrictions were not being accommodated, but could not indicate when they were.

Davis testified that petitioner told her she was overusing her left arm, but did not state when this happened. Davis opened up a case for petitioner's left arm. Davis was not aware of petitioner's permanent restrictions with respect to her right arm.

Davis testified that she did not think respondent handled workers' compensation claims appropriately. She did not think respondent's Human Resources Department should have any medical information on employees. She testified that she had issues with tons of cases, and was reprimanded for sending patients to the doctor. She repeatedly reiterated that she was a nurse for the State of Illinois and not for Tyson.

Randall Bunton, production supervisor for respondent from 2003-2014, was called as a witness on behalf of petitioner. Bunton testified that when something happened at work supervisors were expected to step in and help. He testified that he trained petitioner. He testified that petitioner told him she injured her right shoulder when she and other supervisors were told to go to the carcass site and pick up cow guts. This involved filling garbage cans with 40 pounds and then lifting them and putting them in an auger. He testified that he was aware of petitioner's restrictions when she was restricted from any use of the right arm. He testified that during this time she was moved around a lot to different positions. These included the knife line, and packaging and material handling room. He stated that petitioner had problems with stacking boxes off. He testified that he saw her lift boxes up to 83 pounds. He stated that they were all told to do things to get the job done. Bunton testified that he and petitioner were friends. Bunton stopped working for respondent in October of 2014.

Jeanette Banks, who worked for respondent from 1996 to 2013, was called as a witness on behalf of petitioner. Banks testified that she knew petitioner as her supervisor. She stated that she was aware that petitioner had injured her right shoulder pulling meat with her right arm off a belt. She was unaware of any restrictions petitioner had. She testified that after petitioner injured herself she no longer worked with her. She testified that she does not know how respondent handled petitioner's injuries.

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

Case 10 WC 21755 - Injury to Right Shoulder

The parties stipulated that petitioner sustained an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent on 6/22/09.

Case 11 WC 45991 - Alleged Injury to Left Shoulder

Petitioner alleges that she sustained an accidental injury to her left shoulder due to overuse of her left shoulder while she was restricted from using her right arm at work following the surgery to her right shoulder.

Petitioner underwent surgery to her right shoulder on 11/13/09. She was released to light duty work on 4/18/10 that included no lifting no more than 25 pounds with her right arm. Following the surgery to her right shoulder petitioner underwent a course of physical therapy. On 5/18/10 Dr. Sanchez-Sotelo released petitioner to return to work with lifting up to 25 pounds, ability to perform repetitive motion, and the ability to work 12 hour shifts. On 5/25/10 petitioner reported that she had returned to full duty work as a manager in the packaging department. She testified that she spent 75% performing her supervisory role and 20% working the line. She testified that when working the line she may have to pick up some product from the floor and place it in a container requiring her to reach over at the waist level, and transferring product from the lines into the boxes. She testified that the max weight she would lift from the floor could be up to 90 pounds, overhead reach would be rare and not over 30 pounds. She also testified that she was working a 12 hour shift.

Petitioner testified that respondent honored her restrictions until the tape was removed from her right arm. However, she did not testify as to when that was, or what duties she performed after that date that were outside her restrictions. Petitioner testified that while her right arm was taped she would use her left arm to throw product off the line when the machines broke down. She also testified that she used a 180 pound fire hose to wash the line off. She testified that this happened several times, but provided no specific or detailed information regarding the frequency.

Despite her testimony at trial regarding all her problems with her shoulders at work, on 7/8/10 petitioner reported to her therapist that things were going well and that her right arm/shoulder was not limiting her much anymore. As of this date petitioner made no mention of any problems with her left arm. In fact, what she did mention was that her biggest restrictions were with respect to her recreational activities. She reported difficulties throwing a ball, shooting a basketball, and dribbling a basketball. She reported that her right shoulder was 80% improved.

It was only after this that petitioner presented to Dr. Sanchez Sotolo on 8/6/10 and complained of left shoulder complaints for the first time. She reported complaints of increasing pain in her left shoulder with an onset of one week ago, without any significant history of accident. She also only reported that her left shoulder was painful, particularly when she was doing her hair. At no time on this day, or any day before this did petitioner make any mention of any left shoulder complaints related to her work activities for respondent.

Then, 3 days later on 8/9/10, petitioner drafted a letter to "To Whom It May Concern". In it she wrote "Last Saturday July 31, 2010, I was at home brushing my hair and immediately when I went up to brush my hair again my arm wouldn't go pass my shoulder. This lasted about 10-15 min, that I couldn't extend my left arm up. Friday, August 07, 2010 I was getting ready to go into therapy and went to put my hair up and once again my arm wouldn't extend pass my shoulder. Both times it left me in a great deal of pain, but a couple days later, I felt nothing. This is really bothering me."

That same day petitioner also completed an Employee Injury/Illness Statement. She described her injury as "can't use (L) arm pass (sic) the shoulder occasionally". In response to what she thought caused her problem she wrote "not use (sic) to using left arm had surgery on the right (right handed)". Where asked what she was doing when she first noticed the problem she wrote "brushing her hair". She identified the date of injury as 7/31/10. She noted that the injury was work related and that she told her supervisor. However, she could not recall what supervisor she reported this to, or when she reported this. In response to any aspects of her job which she thought was causing or aggravating her condition, she wrote " No use of right arm for several mths, or possibly injured when right arm, not sure". The arbitrator finds it significant that petitioner did not identify any specific aspects of her job that caused or aggravated her condition, and that despite her claims that her job was causing or aggravating her left shoulder, she made no mention of any left shoulder complaints before 7/31/10,and then it was only respect to 2 specific instances where she was brushing her hair.

The arbitrator finds it significant that about 6 weeks later when petitioner presented to Dr. Sanchez-Sotelo on 9/20/10 she noted that she had no problems with her left shoulder, until she woke up one morning with a sponataneous episode of acute shoulder pain that lasted for 24 hours, and then the pain went away completely. She also reported a similar episode, that also improved. Again, there was absolutely no mention of any problems with her left shoulder associated with her work duties for respondent. The arbitrator finds these reports by petitioner only strengthen the fact that petitioner had no problems with her left shoulder until she was brushing her hair on 7/31/10.

On 3/8/10 petitioner had a repeat left shoulder MRI that showed her tendinopathy had continued to improve.

Despite this improvement, on 4/12/11 petitioner completed a Leave of Absence Application requesting a leave from 4/11/11 through 4/30/11 for medical leave that was non-work related. This leave was ultimately extended through 4/16/12. Petitioner signed this Application.

After Dr. Sanchez-Sotelo drafted a letter to petitioner denying her request for a letter that would state she could not drive because of her chronic use of Vicodin, given the fact that Dr. Sanchez-Sotelo did not believe that her shoulders justified continued use of Vicodin, petitioner sought treatment for her left shoulder from a different healthcare provider, Dr. Collins, on 5/12/11. Petitioner gave Dr. Collins a history that her left shoulder pain was caused from over use of the left arm following surgery on the right shoulder 4 months ago. The arbitrator finds this history inconsistent with the credible medical records that show petitioner had surgery on her right shoulder about a year and a half prior on 11/13/09. She then goes on to state that the onset of her left shoulder problems was on 7/31/10, which the arbitrator notes was the date she had an insidious onset of pain in her left shoulder while she was combing her hair. Petitioner then stated that she lifts 30 pounds or more a lot at work. However, she failed to offer any details regarding her job duties, nor did she provide a job description to support this claim. In fact, the arbitrator notes that the petitioner had previously reported that she really did not know how her left shoulder problems came about at work. She only had left shoulder complaints when she was brushing her hair on 7/31/10 and again on 8/7/10. For these reasons, the arbitrator finds the history petitioner provided Dr. Collins to be inconsistent with the credible evidence.

Following her left shoulder surgery on 7/27/11 petitioner underwent a course of physical therapy. At her Initial Evaluation on 9/30/11 she gave yet another history of the onset of her left shoulder symptomatology. Petitioner reported to her therapist that her left shoulder problems only started while working full duty in early 2011. The arbitrator finds this would put the onset of her left shoulder complaints at about 6 months after her alleged accident date.

The arbitrator finds this accident history inconsistent with the letter petitioner drafted on 8/9/10, and the Employee Injury/Illness Report she drafted that same day, in which she reported 2 very specific onsets of left shoulder pain on 7/31/10, and 8/7/10 while brushing her hair. Petitioner specifically alleged that this was the first time she noticed any problems with her left shoulder. Based on these very specific claims, the arbitrator find the petitioner's further claims that she "thought" her left arm symptoms were due to the fact that she did not use her right arm for several months, or the possibility that she injured her left shoulder when she injured her right shoulder, to be without merit. The arbitrator also finds it significant that although petitioner repeatedly testified that she reported this alleged left shoulder injury to her supervisor, she could not recall who she reported to, or when she reported it.

Given the fact that the burden is on the petitioner to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder that arose out of and in the course of her employment by respondent on 7/31/10, the arbitrator finds the petitioner has failed meet this burden of proof. The arbitrator finds the accident history provided in her testimony, her documented reports and letters, and what she reported to her various healthcare providers was inconsistent, and cannot be relied on. With respect to the alleged accident date of 7/31/10, the arbitrator finds the only thing that happened on that day, which petitioner specifically alleged in her letter of 8/9/10, was that she had an immediate onset of pain in her left shoulder when she went to brush her hair on 7/31/10 that lasted about 10-15 minutes. The arbitrator also finds it significant that on 7/8/10 petitioner reported that she participates in multiple recreational activities that include throwing a ball, shooting a basketball, and dribbling a basketball, and specifically reported difficulties with these activities, but not her work activities.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm.

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

10 WC 21755 - Right shoulder injury

This issue is not in dispute with respect to this claim. The parties stipulated that petitioner's current condition of ill-being as it relates to her right shoulder is causally connected to the injury she sustained on 6/22/09.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue moot.

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?

10 WC 21755 - Right shoulder injury

This issue is not in dispute with respect to this claim.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue moot.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

10 WC 21755 - Right shoulder injury

The parties have stipulated that the petitioner was temporarily totally disabled from 11/13/09-2/28/10, a period of 15-3/7 weeks. The respondent has paid the petitioner $10,995.02 in temporary total disability benefits, and $712.88 in temporary partial disability benefits.

The petitioner is claiming she is entitled to maintenance benefits from 7/14/14 to 8/1/15, a period of 54-5/7 weeks. Respondent denies that petitioner is entitled to any maintenance benefits.

Following petitioner's surgery to her right shoulder on 11/13/09 petitioner was returned to light duty work on 2/28/10. At first, she was restricted from any use of the right upper extremity. On 4/18/10 she was restricted from lifting no greater than 25 pounds in the right hand. On 5/18/10 Dr. Sanchez-Sotelo again restricted petitioner from lifting over 25 pounds. He was of the opinion that petitioner could perform repetitive motion work, and work 12 hour shifts. Petitioner testified that she returned to work, and at times performed lifting in excess of her restrictions, but never provided any specific evidence of this.

On 9/20/10 Dr. Sanchez-Sotelo examined petitioner and noted that her right shoulder seemed to be doing quite well. On 11/22/10 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that her right shoulder was completely healed and she did not have permanent restrictions in terms of lifting. Petitioner continued in physical therapy.

On 1/3/11 Dr. Sanchez-Sotelo noted that he did not think petitioner could lift 60 to 100 pounds in the future. He also noted that a repeat MRI of the right shoulder showed her previous repair was healed, tendinopathy of the supraspinatus. He was of the opinion that it looked like the deeper portion of the supraspinatus had retracted to the level of the midportion of the humeral head. Dr. Sanchez-Sotelo's diagnosis was persistent pain in the right shoulder with a previous subscapularis/supraspinatus repair with evidence of a partial recurrence of the supraspintus tearing on the articular side of the joint.

On 3/29/11 and 3/30/11 petitioner underwent a FCE. A formal job comparison could not be completed since a job description was not available for her position. However, based solely on petitioner's history that if

the line breaks down she must help with the manor labor which could require 60-100 pounds of weight handling, the evaluator was of the opinion that the petitioner's physical abilities would not match her claim if she would need to do 60-100 pounds of weight lifting. The results of the FCE showed that petitioner demonstrated the ability to statically push 70 pounds, and pull 80 pounds; the ability to lift floor to waist 20 pounds, occasionally (heavy level); ability to lift overhead up to 15 pounds, occasionally (heavy level); the ability to carry up to 20 pounds, occasionally (heavy level); the ability to carry with the right upper extremity up to 15 pounds, occasionally (heavy level); and the ability to carry with the left upper extremity up to 20 pounds, occasionally (heavy level).

On 4/12/11 petitioner went off work for a non-work related medical leave. On 4/26/11 and 5/10/11Dr. Sanchez-Sotelo drafted letters to petitioner informing her that he could not envision any further treatment that would help her right shoulder. On 5/21/11 Dr. Sanchez-Sotelo signed a form indicating that petitioner was at MMI with permanent restrictions as determined by the FCE.

While on her non-work related medical leave that was extended 9 times through 4/16/12, petitioner treated for her left shoulder, including surgery on 7/27/11. Following surgery petitioner complained of many left upper extremity problems that Dr. Collins had no medical explanation for, despite various diagnostic tests, that came back normal. Petitioner was ultimately released from care by Dr. Collins on 1/6/12. He released petitioner to full duty work without restrictions for her left shoulder.

After her non-work related medical leave ended on 4/16/12 petitioner was returned to work with permanent restrictions, on the 2nd shift, which was 2:30 pm-2:00am. Petitioner was not happy on this shift because she did not see her kids often. Petitioner testified that her job duties were the same as they were before her accident. Petitioner's duties as a supervisor were to make sure team members knew the specifics of products, made sure the orders were met, make sure yields were there, held safety meetings, and ensure quality for the customers. Petitioner worked in this position without incident for 2 years. However, since she did not like working the 2nd shift, she began putting in for jobs in other departments. It was petitioner's own decision to look for alternate employment due to personal reasons.

Petitioner was ultimately transferred to a Safety Management Position in Wisconsin in March of 2014. This was a job petitioner had applied for. Petitioner testified that she made more money in this position, approximately $2,000 more a year. Petitioner remained in this position until 7/14/14 when she, and other employees at that plant, were placed on a permanent layoff. Other employees were told to apply for other jobs, and were transferred to other states. Petitioner refused to apply for the job in Nebraska that respondent told her to apply for, based on the recommendation of her attorney, and her husband. The arbitrator finds it significant

that although she would not apply for the job in Nebraska that respondent recommended she apply for, she had no trouble applying on her own for jobs as far away as New Jersey and Pennsylvania.

For these reasons the arbitrator finds the petitioner is not entitled to any maintenance benefits. It is unrebutted that respondent returned petitioner to work in a supervisory position, similar to the one she had before the accident, that accommodated her permanent restrictions. However, since she did not want to work the 2nd shift she ultimately transferred out of that position 2 years later at her own request.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue moot.

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

10 WC 21755 - Right shoulder injury

Petitioner is alleging that she is entitled to a wage differential pursuant to Sections 8(d)1 of the Act for the injuries sustained to her right upper extremity. In order receive this award of permanent partial disability the petitioner must meet the burden of proof required to demonstrate that the disability caused an impairment of earning capacity unless the petitioner waives her right to an award under Section 8(d)1 of the Act.

Section 8(d)1 of the Workers' Compensation Act deals with the employee who sustains an accidental injury and as a result becomes partially incapacitated from pursuing her usual and customary line of employment. Additionally, if the employee has permanently reduced earnings as a result of the disability, compensation can be awarded based on a percentage of the difference between the average amount the employee earned before the accident and the average amount the employee is earning or is able to earn in some suitable employment or business after the accident.

Petitioner served in a supervisory capacity at the time of her injury and returned to a supervisory position after her injury, which was within her permanent restrictions. The supervisory position she was returned to was on the 2nd shift. Thereafter, petitioner became unhappy working the 2nd shift, and as a result, she applied for various other jobs with respondent and was ultimately transferred to a Safety Management Position in Jefferson, WI. in March of 2014. In this new position petitioner received an increase in wages. The arbitrator finds it significant that although the petitioner repeatedly claimed that she was required to perform work in excess of her restrictions in her new supervisory position, she provided no specific details regarding when this occurred, the alleged supervisors she reported this to, and when she reported these instances to them. Additionally, the

petitioner failed to offer into evidence a job description for the job she was returned to after she was placed on permanent restrictions. For these reasons, the arbitrator finds the petitioner's testimony that she transferred positions because she did not see her kids enough when she worked the 2nd shift is more persuasive than her claims of performing work outside her permanent restrictions.

In July of 2014 petitioner, and many other employees in the Jefferson, WI plant, where petitioner was working at that time, were laid off permanently. When this occurred, respondent recommended that petitioner apply for a job with respondent in Nebraska. Respondent also recommended other out of state positions for other employees who were permanently laid off. Petitioner refused to apply for this job at the direction of her attorney and her husband. Instead, she began looking for jobs on her own. Her job search log shows that although she would not apply for the position respondent recommended in their Nebraska plant, she had no problem applying on her own for jobs as far away as New Jersey and Pennsylvania.

Although petitioner graduated from American Intercontinental University in 2009, and got her Masters Degree in Business Administration and Human Resources in 2012, she ultimately took a job as a sales consultant with LuJack Auto Sales on 8/2/15. From 7/14-8/15 petitioner's job log only shows that she applied for 52 jobs, with more than half of them being with respondent, but never applying for the job respondent recommended she apply for. The arbitrator finds it significant that in over a year period, the petitioner averaged less than 1 job search a week, and in reality when long periods of time without even looking for a job.

Petitioner testified that she earned $44,000 working for LuJack in 2016. However, the only evidence she offered with respect to this claim was a few paychecks she received from 10/16/16 through 12/31/16, despite the fact that she worked for LuJack from August of 2015 to present. Petitioner only provided paychecks for the last 2 1/2 months of paychecks 2016, and did not provide any W-2 for 2016 that would have shown her actual earnings for 2016. Additionally, with respect to 2017, petitioner did not provide any evidence of what she was earning.

Based on the above, the arbitrator finds the petitioner has failed to prove all the elements of a wage differential pursuant to Section 8(a) of the Act. First and foremost, the arbitrator finds that when the petitioner returned to work for respondent with permanent restrictions she was placed in a supervisory role, which was her usual and customary line of employment with respondent. At no time while in that position did petitioner present credible evidence to show that she was unable to pursue this line of employment. In fact, it was the petitioner who testified that she decided to look for alternate employment because she did not like working the second shift. The arbitrator finds this testimony supports a finding that petitioner left her usual and customary line of employment after her injury solely due to personal reasons.

Additionally, the arbitrator finds the petitioner has failed to prove by the preponderance of the credible evidence that her earnings were permanently reduced as a result of the disability. First, the arbitrator finds that when petitioner was returned to work with permanent restrictions, in her usual and customary line of employment, she offered no evidence to support a finding that her earnings were reduced. In fact, when petitioner voluntarily left this supervisory position to take to the Staff Management Position in Jefferson, WI, her wages actually increased by another $2,000 a year.

Assuming arguendo, one was to look at petitioner's job at LuJack to determine if petitioner's earnings were permanently reduced, the arbitrator finds the petitioner has failed to provide sufficient evidence to prove this element of her claim. The petitioner testified that she has worked for Lujack since August of 2015, a period of about a year and a half. However, what petitioner has actually earned during that period, or is currently earning today, is unknown, based on the fact that petitioner has failed to offer any evidence to support this claim. Petitioner only saw fit to enter into evidence a few payroll stubs from the October-December of 2016 in support of her claim. The arbitrator finds these select paystubs are insufficient evidence to support a claim that her earnings are permanently reduced. Petitioner failed to offer into evidence any payroll stubs for the period August 2015-September 2016, or any payroll stubs from 2017. For these reasons, the arbitrator finds the petitioner has failed to show that her earnings have been permanently reduced.

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she is entitled to a wage differential pursuant to Section 8(d)1 of the Act, the arbitrator finds the petitioner is entitled to a permanent partial disability pursuant to Section 8(d)2 of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, petitioner was a supervisor for respondent. In April of 2012, following treatment for her left shoulder, petitioner was released with permanent restrictions with respect to her right shoulder, and full duty with respect to her left shoulder. Petitioner was returned to her usual and customary line of employment as a supervisor for respondent, albeit on the 2nd shift. At some point while working as a supervisor on the 2nd shift petitioner decided that she did not like working the 2nd shift because she did not see enough of her kids. For this reason, petitioner began applying for alternate jobs with respondent and two years later, in April of 2014, petitioner transferred to a better paying job for respondent in a Safety Management Position in Jefferson, WI. Based on this evidence the arbitrator finds the petitioner was able to continue working in her usual and customary line of employment as a supervisor with

permanent restrictions, until she decided for personal reasons she no longer no wanted to continue her usual and customary line of employment for respondent. Based on these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 44 years old at the time of the accident. After the accident, petitioner was returned to her usual and customary line of employment as a supervisor for respondent, with permanent restrictions. Petitioner worked in this capacity for 2 years without any documented complaints, until transferring to a better paying job for respondent where she could work a different shift. When petitioner was permanently laid off from this position she was told to apply for a different position with respondent, as were other employees at that location who were permanently laid off. However, petitioner declined and began her own job search. Although petitioner has a Bachelor's degree from American Intercontinental University, and a Masters Degree in Business Administration and Human Resources, petitioner has chosen to work for LuJack as a sales consultant. Based on these facts, 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 finds the petitioner's evidence with respect to her future earnings was scant as best. For the year and half she has worked for LuJack she only decided to offer into evidence two months of payroll stubs, that were not her most recent. It is unclear why petitioner did not offer into evidence her most current payroll evidence from LuJack. Because of this the Arbitrator therefore gives little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator adopts the findings and opinions of the FCE performed on 3/29/11 and 3/30/11, and adopted by Dr. Sanchez-Sotelo. As a result of the FCE petitioner demonstrated the ability to statically push 70 pounds and pull 80 pounds; ability to lift floor to waist 20 pounds, occasionally (heavy level); ability to lift overhead up to 15 pounds, occasionally (heavy level); ability to carry up to 20 pounds, occasionally (heavy level); ability to carry with the right upper extremity up to 15 pounds, occasionally (heavy level); ability to carry with the left upper extremity up to 20 pounds, occasionally (heavy level). Because of this 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 a permanent partial disability to the extent of 37.5% loss of use of her person as a whole, pursuant to §8(d)2 of the Act.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ZINA RIOS,

Petitioner,

vs. NO: 11 WC 45991

TYSON FRESH MEATS, INC.,

Respondent.

18IWCC0545

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, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. A separate Decision has been issued for case number 10 WC 21755.

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

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

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

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

DATED: SEP 5 - 2018

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB/pm
D: 08-28-18
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

RIOS, ZINA
Employee/Petitioner

Case# **10WC021755**

11WC045991

TYSON FRESH MEATS INC
Employer/Respondent

18IWCC0545

On 5/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0222 GOLDBERG WEISMAN & CAIRO LTD
DANA N BLUMTHAL
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

2593 GANAN & SHAPIRO PC
PAUL D DYKSTRA
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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
CORRECTED ARBITRATION DECISION

ZINA RIOS,
Employee/Petitioner

v.

TYSON FRESH MEATS, INC.,
Employer/Respondent

Case # 10 WC 21755

Consolidated cases: 11 WC 45991

18IWCC0545

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Rock Island**, on **3/8/17**. 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 _____

FINDINGS

On **6/22/09 and 7/31/10**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

On 6/22/09, Petitioner *did* sustain an accident to her right shoulder that arose out of and in the course of employment.

On 7/31/10, Petitioner *did not* sustain an accident to her left shoulder that arose out of and in the course of employment.

Timely notice of the accidents *was* given to Respondent.

Petitioner's current condition of ill-being as it relates to her right shoulder *is* causally related to the accident on 6/22/09.

Petitioner's current condition of ill-being as it relates to her left shoulder *is not* causally related to the accident on 7/31/10.

In the year preceding the injury on 6/22/09 and 7/31/10, Petitioner earned $**53,446.25**; the average weekly wage was $**1,068.93**.

On 6/22/09, Petitioner was **44** years of age, *married* with **2** dependent children.

On 7/31/10, Petitioner was **45** years of age, *married* with **2** dependent children.

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

Respondent *has or will* pay all appropriate charges for all reasonable and necessary medical services for the right shoulder. Respondent will not pay any charges for medical services for the left shoulder.

Respondent shall be given a credit of $**10,995.02** for TTD for the right shoulder, $**712.88** for TPD for the right shoulder, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**11,707.90**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $712.62/week commencing 11/13/09 through 2/28/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits totaling $712.88 for the period 3/1/10 through 3/14/10, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $641.36/week for 187.5 weeks, because the injuries sustained caused the 37.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

5/5/17
Date

ICArbDec p. 2

MAY 8 - 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 44 year old supervisor, sustained an accidental injury that arose out of and in the course of her employment by respondent on 6/22/09 (10 WC 21755). On this day petitioner injured her right shoulder while picking up pieces of intestines and putting them into barrels. This case was heard in consolidation with case 11 WC 45991 (11 WC 45991) which involves an alleged overuse of the left arm due to petitioner's injury to her right arm. The alleged accident date for that case is 7/31/10.

Petitioner worked for respondent from 1994 to 2014. Petitioner began as a team member on the floor. She worked in Quality Assurance for 5 1/2 years. She was then a Sanitation Supervisor for 3 1/2 years. She was then a Production Supervisor in the pork division, and then worked in the Sales Department to learn the beef side of the business. After that petitioner worked on the A shift as a training supervisor to further her education in the beef side of the business.

Petitioner testified that she injured her right shoulder while working in the beef division. She stated that her job was to set up the line for team members. She would teach them the specifications of the product and the meat schedule.

Petitioner graduated from American Intercontinental University in 2009. In 2012 she got her Masters Degree in Business Administration and Human Resources. Petitioner currently works at Lujack Auto Plaza as a sales consultant. She has worked there for about 1 1/2 years. Her current duties are helping people find cars and online chats.

Petitioner testified that on 6/22/09 she was sent to the rendering area, an area where she had never been before. She testified that there were cow intestines up to her knees. She testified that she had to put on a rubber suit and put the intestines into a barrel, and then pull the barrel along the assembly line. She stated that the product weighed 100 pounds. She testified that she and other managers were called in to perform this job. Later in her testimony she stated that was performing these duties on a regular basis when the belts were not working.

When petitioner got home she went into her Jacuzzi. She testified that it was then that she noticed a bone sticking out of her right shoulder. She testified that she called her supervisor, Aaron Johnson, on his cell phone.

Petitioner testified that she was not sent to Concentra until 2 months after the injury. However, the medical records show that on 6/22/09 she presented to Dr. Eugene Gaertner at Concentra Medical Centers. She reported an injury to her right shoulder while working for respondent on 6/22/09. She stated "I am not sure what exactly hurt my shoulder at work". She reported that the pain began gradually. The pain was located on the acromioclavicular joint of the right shoulder and lateral aspect of the right shoulder. She stated that she

experienced no pain initially. She rated her pain at a 1/10. She noted that the pain radiated to the right arm. An x-ray of the right shoulder was negative. She had full range of motion, and normal rotator cuff motion. No tenderness was present, but swelling was noted at the AC joint. She was assessed with an acromioclavicular strain. Petitioner was released to work with no restrictions.

On 6/30/09 petitioner presented to Dr. Dunbar at Concentra Medical Centers. She reported that she did not have problems except local pain until a self examination revealed a bony prominence over the right AC joint. She was concerned that she had dislocated her shoulder. She complained of occasional discomfort and some diffuse weakness over the upper arm. Petitioner demonstrated some weakness with drop arm test and discomfort with performance of scapcion, and radiation of discomfort to the lateral upper arm with resisted abduction. Petitioner was assessed with a history of a right shoulder contusion, and bony prominence with no abnormalities. X-rays of the acromioclavicular joints with and without weights were normal. Physical therapy was ordered.

Petitioner began a course of physical therapy on 7/1/09 at Rock Valley Physical Therapy. She attributed her symptoms to shoveling of product.

On 7/13/09 petitioner returned to Dr. Gaertner and reported that she had no improvement with physical therapy. However when Dr. Gaertner reviewed the therapy records it was noted that she had approximately a 90% improvement and achievement of the initial goals. She stated that she was working her regular duty job. She reported that she no longer had any significant pain and felt that her function was near normal. She had no radiating pain. Following an examination, petitioner was assessed with shoulder strain-trapezius/rhomboid. Additional physical therapy was recommended and petitioner was released to full duty work.

On 8/10/09 petitioner reported very minimal pain in her right shoulder. She continued to be unhappy about the fact that she had asymmetry of her AC joints. She reported discomfort when she laid on her right side. The therapist examined petitioner and noted complaints of pain, fairly minimal. Petitioner's motion and strength were within normal limits.

On 8/13/09 petitioner followed-up with Dr. Gaertner. Petitioner reported an improvement in her functional status with physical therapy. Petitioner reported that she had minimal pain, but was much better overall, with near normal function. She rated her pain at a 1/10, exacerbated by raising her arms overhead. Petitioner was examined and assessed with acromioclavicular bursitis and shoulder impingement. Petitioner was referred to Dr. Brozovich.

On 9/2/09 petitioner presented to Dr. Brozovich. She gave a history of helping to move a large rolling tub filled with meat products on 6/22/09. She reported a right shoulder injury. Dr. Brozovich was of the opinion that the right acromioclavicular joint was intact. He believed her acromioclavicular joint appeared elevated because she was carrying her right shoulder slightly elevated. Dr. Brozovich diagnosed a possible labral tear.

On 9/2/09 petitioner returned to Dr. Dunbar complaining of deep right shoulder discomfort. She reported pain when she rolls on it or is asked to pull objects from a lower level at work. Dr. Dunbar reviewed petitioner's history of injury and that her pain complaints did not occur until she began physical therapy. Petitioner admittedly agreed. Petitioner stated that she was continuing in her regular duty job and it was not problematic. An MRI arthrogram was ordered. Dr. Dunbar canceled any further chiropractic care. A home exercise program was prescribed. She was released to regular duty.

On 9/14/09 petitioner underwent an MR arthrogram of the right shoulder. The impression was full-thickness tear anterior supraspinatus tendon with partial-thickness undersurface tear of the remainder of the supraspinatus tendon.

Petitioner returned to Dr. Dunbar on 9/18/09, post MRI. Petitioner reported that she was still working her regular job and only had discomfort with certain maneuvers. Dr. Dunbar reviewed the MR arthrogram and assessed a right rotator cuff tear. Dr. Dunbar was of the opinion that petitioner was a surgical candidate and needed to see an orthopedist. Petitioner was not given any restrictions.

On 9/23/09 petitioner presented to Dr. Tuvi Mendel for an orthopedic evaluation. Following an assessment, Dr. Mendel assessed an acute right sided rotator cuff tear. He recommended a shoulder scope, decompression, possible AC joint resection with rotator cuff repair in the near future.

On 11/9/09 petitioner presented to Dr. Sanchez-Sotelo at Mayo Clinic on a self referral for a second opinion regarding her right shoulder. Petitioner gave a consistent history of the accident. She stated that same day after she went home and got into her hot tub she noticed deformity and prominence of the lateral end of the clavicle. She felt some discomfort over the next few weeks, but her symptoms continued to become worse despite physical therapy. Her main complaint was pain at a 4/10 most of the time and an 8 to 9/10 at its worst. Following an examination Dr. Sanchez-Sotelo's impression and diagnosis was right shoulder combined subscapularis full-thickness supraspinatus partial-thickness articular-sided tear.

On 11/11/09 Dr. Sanchez-Sotelo drafted a letter to respondent's claim adjuster. He was of the opinion that it is possible to develop a full-thickness tear from a one-day event, even though he suspected that she probably had some pre-existing deterioration of the tendon that facilitated this injury. He was further of the opinion that

the mechanism of injury described by petitioner may explain an extension of a previous rotator cuff tear. He was of the opinion that it is difficult to determine if petitioner's shoulder injury is the direct result of the 6/19/09 work injury. He believed that if petitioner developed an extension of a previously-compromised tendon during her injury on 6/19/09, it would require the recommended surgery. He was also of the opinion that her shoulder condition may have been aggravated by the 6/19/09 lifting, and the aggravation had not yet resolved.

On 11/13/09 petitioner underwent a right shoulder full thickness supraspinatus tendon tear repair, and right shoulder biceps tenodesis. The post-operative diagnosis was right shoulder rotator cuff tear with associated biceps tendinopathy. Petitioner followed-up post-operatively with Dr. Sanchez-Sotelo. Post-operatively petitioner also underwent physical therapy at Rock Island Physical Therapy from 2/22/10-5/6/10. Petitioner followed-up post-operatively with Dr. Sanchez-Sotelo.

On 2/15/10 Dr. Sanchez-Sotelo released petitioner to work on 3/1/10 part-time for two weeks. He was of the opinion that she would return to work with the understanding that she would not be using the right upper extremity at work. On 4/18/10 petitioner followed up with Dr. Sanchez. Dr. Sanchez gave petitioner restrictions that included lifting no greater than 25 pounds in the right hand.

On 5/6/10 petitioner reported to her physical therapist that the swelling in her arm started to decrease, especially in the last 2 days. Petitioner's main complaint was scrubbing her back in the shower and reaching overhead to put things on a shelf. Petitioner reported that there were a lot of exercises that she could do at home. The therapist noted that petitioner's active shoulder range of motion was improved in flexion and abduction compared to her last treatment series. Petitioner demonstrated improved scapulohumeral rhythm and decreased shoulder hike. Petitioner seemed to have benefitted from a temporary decrease of the strengthening component of rehab for pain modulation and swelling. Petitioner was taped to reposition the humeral head and decrease activation of the upper trap at the end of the treatment.

On 5/18/10 Dr. Sanchez-Sotelo noted that he would like to see here again in November to determine her residual stiffness and that would likely translate into some permanent partial disability. In the meantime, he was of the opinion that petitioner could return to work with the ability now to lift up to 25 pounds of weight. He was of the opinion that petitioner could perform repetitive motion, and work 12 hour shifts. He believed she would benefit from continued physical therapy.

On 5/25/10 petitioner resumed physical therapy at Rock Island Physical Therapy. Petitioner reported that she returned to full duty/full time work for respondent as a manager in the packaging department. Petitioner reported that she spends about 75% of her time completing supervisory roles and the remaining 20% on the line.

If petitioner has to work on the line she may have to pick up product from the floor, and place it in a component requiring her to reach over at the waist level, and transferring product from the lines into boxes. She reported that this may require a lot of twisting motion, mainly to the right. She reported that the max amount of weight she would lift from the floor could be up to 90 pounds. She stated that any overhead reach would be rare and not over 30 pounds. Petitioner stated that she works a 12 hour shift.

Petitioner testified that respondent honored her restrictions until the tape came off her right hand/arm. She stated that after her surgery when she returned to work there was new machinery in the area. She testified that she only used her left arm to throw product off the line and clean off machines. Petitioner testified that when the machine broke down someone was supposed to come in and help, but they did not, and on several occasions when it broke the product piled up. Petitioner testified that on the occasions when the machine broke she would use her left hand to throw the product off the belt and rinse the belt off with a 180 pound fire hose. Petitioner testified that she would pull the 180 pound fire hose with her left hand. She testified that she was only supposed to do a supervisory job.

Despite these reported complaints at trial, on 7/8/10 petitioner reported to her therapist that things were going very well. She stated her arm/shoulder did not limit her much anymore. She stated that her biggest restrictions were with respect to her recreational activities. She reported difficulties throwing a ball, shooting a basketball, and dribbling a basketball. She noted that her perceived improvement was 80%.

On 8/6/10 petitioner notified Dr. Sanchez-Sotelo that she had complaints of increasing pain in the left shoulder without any significant history of injury. She said it had been present for only the last week. She reported that her left shoulder was painful when she lifts the shoulder, particularly when she is doing her hair. She requested that she see Dr. Sanchez-Sotelo as soon as possible.

On 8/9/10 petitioner drafted a note to "To Whom It May Concern". She wrote "Last Saturday July 31, 2010, I was at home brushing my hair and immediately when I went up to brush my hair again my arm wouldn't go pass my shoulder. This lasted about 10-15 min, that I couldn't extend my left arm up. Friday, August 07, 2010 I was getting ready to go into therapy and went to put my hair up and once again my arm wouldn't extend pass my shoulder. Both times it left me in a great deal of pain, but a couple days later, I felt nothing. This is really bothering me. I asked for left arm to be evaluated because I definitely don't want to go through what I had to go through with arm (right)." Petitioner signed the note.

On 8/9/10 petitioner completed an Employee Injury/Illness Statement. She described her injury as "can't use (L) arm pass (sic) the shoulder occasionally". In response to what she thought caused her problem she wrote

"not use to using left arm had surgery on the right (right handed)". Where asked what she was doing when she first noticed the problem she wrote "brushing her hair". She identified the date of injury as 7/31/10. She noted that the injury was work related and that she told her supervisor. However, she did not indicate which supervisor she reported this to, or when she reported this to her supervisor. In response to any aspects of her job which she thought was causing or aggravating her condition, she wrote " No use of right arm for several mths, or possibly injured when right arm, not sure".

At trial petitioner testified that she first claimed a specific injury to her left shoulder, and then reported that she hurt her left shoulder due to overuse because she could not use her right shoulder. She testified that she used her left arm for everything when she could not use her right shoulder. Petitioner testified that her bone jarred when she went brush her hair and that caused her pain. Petitioner testified that her right shoulder was worse after surgery than it was before.

On 8/25/10 petitioner underwent an MRI of the left shoulder. The impression was a nearly 1-cm loose body, likely resulting in the limited range of motion. It was noted that there was either a severe partial tear or a full-thickness tear involving the supraspinatus, and there was extensive tendinopathy or a partial tear involving the infraspinatus and subscapularis. A SLAP tear of the labrum was suspected. Also noted was a probable low grade cartilaginous lesion in the humerous. Plain film correlation was recommended to confirm a calcified loose body as well as to evaluate the proximal humeral lesion.

On 9/7/10 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that he reviewed the MRI of her left shoulder. He was of the opinion that it showed a tendon tear in the left shoulder as well as maybe a ligament injury in the labrum. He was of the opinion that these tears may benefit from surgery depending on how she responds to steroid injections and physical therapy.

On 9/20/10 Dr. Sanchez-Sotelo noted that petitioner's right shoulder seemed to be doing quite well. He noted that she had no problems with the left shoulder until she woke up one morning with a spontaneous episode of acute shoulder pain that lasted for about 24 hours, and then the pain went away completely. She reported a 2nd episode like that, that also improved. Dr. Sanchez-Sotelo noted that petitioner's x-ray of the left shoulder showed a lesion on the upper third of the humeral shaft consistent with an enchondroma. He noted that the MRI showed tendinopathy affecting the supraspinatus and subscapularis tendons as well as some thickening around the biceps tendon and the labrum. His impression was left shoulder pain consistent with labral versus biceps pathology versus supraspinatus tendinopathy, and possible left humerus enchondroma versus low-grade malignant chondral tumor. Dr. Wegner did not think the lesion had the characteristics of malignancy right now, but was of the opinion that the lesion needed follow-up.

On 11/22/10 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that her right shoulder was completely healed and she did not have permanent restrictions in terms of lifting.

On 1/3/11 petitioner returned to Dr. Sanchez-Sotelo for follow-up of her right shoulder. She complained of difficulty with both shoulders. She stated that she was lifting up to 25 pounds at work. She stated that she was told she is expected to lift between 60 and 100 pounds. He did not think she could lift that in the future. A repeat MRI of the right shoulder showed her previous repair was healed, but she had tendinopathy of the supraspinatus and it looked like the deeper portion of the supraspinatus had retracted to the level of the midportion of the humeral head. Dr. Sanchez-Sotelo's diagnosis was persistent pain with a previous subscapularis/supraspinatus repair with evidence of a partial recurrence of the supraspinatus tearing on the articular side of the joint.

On 1/25/11 petitioner resumed physical therapy at Rock Valley Physical Therapy. She reported that after returning to work full duty she "wasn't using my arm because afraid was going to hurt it". She started to report pain, aching, and tingling throughout her right upper extremity. She reported that she spends approximately 20% of her day on the line reaching, pulling, transferring product from the line into boxes. She states that the max lift could be up to 100 pounds floor to waist, but infrequently. She stated that the max waist to overhead would be up to 30 pounds.

On 3/4/11 petitioner was discharged from physical therapy. Her overall condition was seen as "improving". The therapist was of the opinion that petitioner exhibited a fair prognosis at time of discharge from skilled rehabilitative therapy in conjunction with a home exercise. The therapist noted that the petitioner was independent in her home exercise program. Her current pain level was 6/10. Her functional tests showed floor to waist max lift of 50 pounds, and overhead max lift with right hand was 25 pounds, and max lift with left hand was 30 pounds. Her flexion on left was 160 to 150 degrees on right, and abduction was 150 on left and 130 on right. Petitioner had increased symptoms with horizontal abduction test.

On 3/8/11 petitioner underwent a repeat MRI of the left shoulder that showed that her tendinopathy had continued to improve. An FCE was prescribed.

On 3/29/11 and 3/30/11 petitioner underwent a Functional Capacity Evaluation (FCE). A formal job comparison could not be completed since a job description was not available for her position. She reported that even though her primary responsibility is being a manager, if the line breaks down she must help with much of the manual labor, which could require 60-100 pounds of weight handling. It was noted that petitioner's physical abilities would not match the requirement of 60-100 pounds of weight lifting. Petitioner demonstrated the

ability to statically push 70 pounds and pull 80 pounds; ability to lift floor to waist 20 pounds, occasionally (heavy level); ability to lift overhead up to 15 pounds, occasionally (heavy level); ability to carry up to 20 pounds, occasionally (heavy level); ability to carry with the right upper extremity up to 15 pounds, occasionally (heavy level); ability to carry with the left upper extremity up to 20 pounds, occasionally (heavy level).

On 4/5/11 Dr. Sanchez-Sotelo drafted a letter to petitioner after she called him trying to obtain a letter that would state she could not drive because of her chronic use of Vicodin. Dr. Sanchez-Sotelo was of the opinion that he did not believe that her shoulders justified continued use of Vicodin.

On 4/12/11 petitioner completed a Leave of Absence Application requesting a leave from 4/4/11 through 4/30/11 for a medical leave that was non-work related. Petitioner extended this leave to 5/2/11, 5/26/11, 6/10/11, 7/28/11, 8/11/11, 11/25/11, 12/6/11, 4/4/12, and 4/16/12. On cross-examination petitioner denied that she signed them. She testified that these forms were for her left shoulder. She stated that she was on a lot of medication at the time and did not understand the form and the fact that she checked on the form that the injury was not work related. On cross-examination she testified that she was told to sign it or she would be terminated.

On 4/18/11 petitioner underwent an MR arthrogram of the left shoulder. The findings were similar to the findings on 8/25/10. There was an approximately 1 cm loose body in the anterior subacromial-subdeltoid bursa that could be the result of a full-thickness tear which allowed a piece of synovium to enter into subacromial bursa and then enlarge. It was noted that this loose body could be having some mass effect and restricting range of motion. Also noted was a focal full-thickness tear of the far anterior distal inserting fibers of the supraspinatus tendon, and stable, and likely low-grade chnodroid lesion of the proximal left humeral diaphysis.

On 4/26/11 and 5/10/11 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that he could not envision any further treatment that would help her right shoulder.

On 5/12/11 petitioner presented to Dr. Scott Collins for her left shoulder. She identified the onset of her problem as 7/31/10 with no specific injury. She noted that her left shoulder pain was caused from over use of that arm due to surgery on the right shoulder 4 months ago. Petitioner reported sharp pain in her left shoulder that radiates up and down her arm. She noted that her left hand swells. She complained of lifting 30 pounds or more a lot at work. She also described constant pain in her neck, shoulder and back lifting product from 30 pounds to 50+ pounds every day, pulling product out of combos, or stacking on pallets. Dr. Collins assessed left shoulder pain. He recommended a left shoulder arthroscopy with debridement and chromioplasty. X-rays of the left shoulder demonstrated some degenerative changes of the left shoulder with some hooking of the acromion,

mild acromioclavicular. A chip of the bone was possible. Dr. Collins thought it was calcific tendinosis, that appeared to be an enchrondroma in her proximal humerus.

On 5/21/11 Dr. Sanchez-Sotelo signed a form indicating that she was at maximum medical improvement for her right shoulder with permanent work restrictions as determined by the FCE.

On 7/27/11 petitioner underwent a left shoulder arthroscopy, anterior labral tear repair arthroscopically, debridement, mini open rotator cuff repair, removal of loose body from the subacromial space, acromioplasty, rotator cuff repair, and removal of spurs on the acromioclavicular joint. The post-operative diagnosis was foreign body, rotator cuff tear, degenerative changes in the left shoulder and acromial hooking. This surgery was performed by Dr. Collins. Petitioner followed up post-operatively with Dr. Collins. The treatment included physical therapy. Petitioner was authorized off work.

On 8/16/11 Dr. Collins completed an Initial Claim Report for Disability Insurance for CUNA Mutual Group. The date the disability began was on 7/27/11, and her symptoms began on 7/31/10 while stocking product on pallets.

On 9/30/11 petitioner returned to physical therapy at Rock Valley Physical Therapy. She stated that while working full duty in early 2011 her left shoulder started to hurt. Petitioner reported that she took the medicine she was using for her right shoulder for her left shoulder. However, when she got off medication for right shoulder to do her final deposition on her right shoulder, her pain in her left shoulder increased significantly.

On 12/13/11 petitioner underwent an MRI of the cervical spine due to neck pain with radiation to the left shoulder. The impression was mild diffuse disk bulging most prominently at the C4-C5 level. No central spinal stenosis or focally herniated disk. There was no evidence of left neural foraminal stenosis to account for petitioner's left-sided symptoms.

On 12/20/11 petitioner told Dr. Collins that she was still having left shoulder pain as well as tingling and sharp pain that shoots down to the dorsal aspect of her left hand. She stated that it comes and goes, and was an 8/10 in severity. Dr. Collins impression was status post left shoulder arthroscopy, debridement, acromioplasty, distal clavicle excision, with open rotator cuff repair and removal of loose body, and left arm paresthesias. An EMG/NCV was ordered.

On 12/30/11 Dr. Robert Chesser performed an EMG/NCV, for her complaints of left upper extremity pain. She reported pain in her left scapular region that extends into the left arm and at times numbness in the left hand. Dr. Chesser noted somewhat limited cervical active range of motion in all planes; moving rather guardedly; complaint of pain in the left upper trapezius with forward flexion; increased pain with extension and

left rotation; and complaints of pain into the right upper trapezius with right rotation. The electrodiagnostic testing was normal. No entrapment of the median nerve or the ulnar nerve was confirmed.

On 1/6/12 petitioner reported to Dr. Collins that she was doing somewhat better. She complained of some left shoulder pain, as well as numbness and tingling that shoots down to the dorsal aspect of the left hand. She reported that the paresthesias was intermittent. Dr. Collins had no medical explanation as to why petitioner was experiencing the paresthesias of the left arm. He recommended that she continue activities as tolerated. Dr. Collins released petitioner to full duty work without restrictions.

On 1/17/12 petitioner was discharged from physical therapy for her left shoulder. Petitioner demonstrated a good prognosis from skilled rehabilitative therapy in conjunction with a home exercise program. Petitioner's pain was 2/10. She was found capable of working full duty unrestricted work. Her left arm flexion was 150, her abduction was 120 and her external rotation was 50 degrees. Her musculoskeletal improvement in her left shoulder showed muscle strength within normal limits.

Petitioner testified that when she was released to full duty work following treatment for her left shoulder she was placed on the B shift (evening shift). She worked from 2:30 pm to 2:00 am. She testified that she had been working the A shift because her daughter had seizures, and when working the second shift she did not see her kids. Petitioner testified that her duties on the 2nd shift were the same as those she had on the 1st shift. Since petitioner did not like working the 2nd shift she testified that she put in for jobs in other departments. As a supervisor petitioner's job was to make sure team members knew specifics of products, make sure orders were met, make sure yields were there, hold safety meetings, and ensure quality for the customers.

Petitioner testified that when she was released to full duty after her left shoulder surgery respondent was not honoring her lifting restrictions for her right arm. She testified that she was a packaging supervisor and when the belts and conveyors broke down she would have to throw the product into a big box. She testified that all this product weighed more than 20 pounds, and some weighed 100 pounds. She testified that she made complaints to her supervisors that she was not working within her restrictions, but did not provide any of the names of the supervisors or when she reported these complaints.

Petitioner testified that because she was working outside her restrictions on a constant basis when the conveyors shut down she started looking for a new position with respondent. She testified that the job she was doing was tearing up her body. She testified that she applied for 100 jobs. Petitioner ultimately was transferred to a Safety Management Position in Wisconsin in March of 2014. Petitioner earned more in this position. She testified that it was approximately $2000 more a year. In this position, petitioner had to travel to Arkansas for

training. She testified that she had no computer access, and put in a work order to have her computer problems fixed. Petitioner remained in this position until July of 2014. On 7/14/14 petitioner was placed on a permanent layoff from the Jefferson Plant in Jefferson, WI. Petitioner testified that other jobs were also being eliminated at that time in Wisconsin. She testified that her Safety Manager was transferred to Chicago, and others were transferred to other new positions in different locations. Petitioner was told to apply for a position in Nebraska. Petitioner did not apply for this position at the recommendation of her attorney and her husband. She also testified that she did not apply for the job in Nebraska because of the way respondent treated her. She testified that her husband told he would not move because of the way respondent treated her. Petitioner testified that she applied for 50 jobs including three Human Resource positions, but did not get any. She never did apply for the position in Nebraska.

Petitioner then looked for a job on her own. Petitioner offered into evidence Job Search Logs that contained 52 contacts from 7/14/14 through 4/7/15. From 7/14/14 through 1/14/15 petitioner applied only for jobs within Tyson. During this period she applied for 24 jobs with respondent. From 8/5/14 through 4/7/15 petitioner applied for 28 jobs outside Tyson, some as far away as Pennsylvania and New Jersey. She testified that she ultimately got the job with LuJack about August 2015.

Petitioner offered into evidence paychecks from 10/13/16 through 1/13/17 from LuJack's. For the period 10/16/16-10/31/16 petitioner earned $833.33 in salary. For the period 10/1/16-10/31/16 petitioner earned $1,411.40 in sales commission. For the period 11/1/16-11/15/16, 11/16/16-11/30/16, 12/1/16-12/15/16, 12/16/16-12/30/16, and 1/1/17-1/15/17 petitioner earned $833.33 in salary each period. For the period 12/1/16-12/1/16 petitioner earned $575.00 for Var Contest. For period 11/1/16-11/30/16 petitioner earned $1,770.39 in sales commission. For the period 12/1/16 through 12/31/16 petitioner earned $1,937.03 in commission.

Petitioner testified that she made $44,000 last year working for Lujack. She further testified that she earned more than $65,000-$68,000 working for respondent. She agreed that she made $53,000 on the date of accident.

Currently, petitioner has difficulty doing activities with her daughter that include softball and basketball. She also reported difficulty with normal housework and yard work, sleeping at night, and dressing herself.

Petitioner testified that while she was off work for her left shoulder she did receive short term disability benefits for her time off.

Courtney Davis, occupational health nurse for respondent from 2008 through June of 2011, was called as a witness by petitioner. Davis' duties included working with employees with work related injuries. Davis testified

that petitioner was originally seen by another nurse, but as she was looking at petitioner she notice a bulge from her clavicle area and immediately completed the paperwork to send her to Dr. Dunbar. She testified that she told petitioner there was nothing she could do for her. Davis testified that she makes sure employees restrictions are accommodated. However, she stated that while walking the floors one day, she saw petitioner tugging a vat of meat and reported it to her supervisor. She stated that petitioner was brought in and told her restrictions would be accommodated. She stated that petitioner was put somewhere else for that day. She testified that she knew of 5 occasions where petitioner's restrictions were not being accommodated, but could not indicate when they were.

Davis testified that petitioner told her she was overusing her left arm, but did not state when this happened. Davis opened up a case for petitioner's left arm. Davis was not aware of petitioner's permanent restrictions with respect to her right arm.

Davis testified that she did not think respondent handled workers' compensation claims appropriately. She did not think respondent's Human Resources Department should have any medical information on employees. She testified that she had issues with tons of cases, and was reprimanded for sending patients to the doctor. She repeatedly reiterated that she was a nurse for the State of Illinois and not for Tyson.

Randall Bunton, production supervisor for respondent from 2003-2014, was called as a witness on behalf of petitioner. Bunton testified that when something happened at work supervisors were expected to step in and help. He testified that he trained petitioner. He testified that petitioner told him she injured her right shoulder when she and other supervisors were told to go to the carcass site and pick up cow guts. This involved filling garbage cans with 40 pounds and then lifting them and putting them in an auger. He testified that he was aware of petitioner's restrictions when she was restricted from any use of the right arm. He testified that during this time she was moved around a lot to different positions. These included the knife line, and packaging and material handling room. He stated that petitioner had problems with stacking boxes off. He testified that he saw her lift boxes up to 83 pounds. He stated that they were all told to do things to get the job done. Bunton testified that he and petitioner were friends. Bunton stopped working for respondent in October of 2014.

Jeanette Banks, who worked for respondent from 1996 to 2013, was called as a witness on behalf of petitioner. Banks testified that she knew petitioner as her supervisor. She stated that she was aware that petitioner had injured her right shoulder pulling meat with her right arm off a belt. She was unaware of any restrictions petitioner had. She testified that after petitioner injured herself she no longer worked with her. She testified that she does not know how respondent handled petitioner's injuries.

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

Case 10 WC 21755 - Injury to Right Shoulder

The parties stipulated that petitioner sustained an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent on 6/22/09.

Case 11 WC 45991 - Alleged Injury to Left Shoulder

Petitioner alleges that she sustained an accidental injury to her left shoulder due to overuse of her left shoulder while she was restricted from using her right arm at work following the surgery to her right shoulder.

Petitioner underwent surgery to her right shoulder on 11/13/09. She was released to light duty work on 4/18/10 that included no lifting no more than 25 pounds with her right arm. Following the surgery to her right shoulder petitioner underwent a course of physical therapy. On 5/18/10 Dr. Sanchez-Sotelo released petitioner to return to work with lifting up to 25 pounds, ability to perform repetitive motion, and the ability to work 12 hour shifts. On 5/25/10 petitioner reported that she had returned to full duty work as a manager in the packaging department. She testified that she spent 75% performing her supervisory role and 20% working the line. She testified that when working the line she may have to pick up some product from the floor and place it in a container requiring her to reach over at the waist level, and transferring product from the lines into the boxes. She testified that the max weight she would lift from the floor could be up to 90 pounds, overhead reach would be rare and not over 30 pounds. She also testified that she was working a 12 hour shift.

Petitioner testified that respondent honored her restrictions until the tape was removed from her right arm. However, she did not testify as to when that was, or what duties she performed after that date that were outside her restrictions. Petitioner testified that while her right arm was taped she would use her left arm to throw product off the line when the machines broke down. She also testified that she used a 180 pound fire hose to wash the line off. She testified that this happened several times, but provided no specific or detailed information regarding the frequency.

Despite her testimony at trial regarding all her problems with her shoulders at work, on 7/8/10 petitioner reported to her therapist that things were going well and that her right arm/shoulder was not limiting her much anymore. As of this date petitioner made no mention of any problems with her left arm. In fact, what she did mention was that her biggest restrictions were with respect to her recreational activities. She reported difficulties throwing a ball, shooting a basketball, and dribbling a basketball. She reported that her right shoulder was 80% improved.

It was only after this that petitioner presented to Dr. Sanchez Sotolo on 8/6/10 and complained of left shoulder complaints for the first time. She reported complaints of increasing pain in her left shoulder with an onset of one week ago, without any significant history of accident. She also only reported that her left shoulder was painful, particularly when she was doing her hair. At no time on this day, or any day before this did petitioner make any mention of any left shoulder complaints related to her work activities for respondent.

Then, 3 days later on 8/9/10, petitioner drafted a letter to "To Whom It May Concern". In it she wrote "Last Saturday July 31, 2010, I was at home brushing my hair and immediately when I went up to brush my hair again my arm wouldn't go pass my shoulder. This lasted about 10-15 min, that I couldn't extend my left arm up. Friday, August 07, 2010 I was getting ready to go into therapy and went to put my hair up and once again my arm wouldn't extend pass my shoulder. Both times it left me in a great deal of pain, but a couple days later, I felt nothing. This is really bothering me."

That same day petitioner also completed an Employee Injury/Illness Statement. She described her injury as "can't use (L) arm pass (sic) the shoulder occasionally". In response to what she thought caused her problem she wrote "not use (sic) to using left arm had surgery on the right (right handed)". Where asked what she was doing when she first noticed the problem she wrote "brushing her hair". She identified the date of injury as 7/31/10. She noted that the injury was work related and that she told her supervisor. However, she could not recall what supervisor she reported this to, or when she reported this. In response to any aspects of her job which she thought was causing or aggravating her condition, she wrote " No use of right arm for several mths, or possibly injured when right arm, not sure". The arbitrator finds it significant that petitioner did not identify any specific aspects of her job that caused or aggravated her condition, and that despite her claims that her job was causing or aggravating her left shoulder, she made no mention of any left shoulder complaints before 7/31/10,and then it was only respect to 2 specific instances where she was brushing her hair.

The arbitrator finds it significant that about 6 weeks later when petitioner presented to Dr. Sanchez-Sotelo on 9/20/10 she noted that she had no problems with her left shoulder, until she woke up one morning with a sponataneous episode of acute shoulder pain that lasted for 24 hours, and then the pain went away completely. She also reported a similar episode, that also improved. Again, there was absolutely no mention of any problems with her left shoulder associated with her work duties for respondent. The arbitrator finds these reports by petitioner only strengthen the fact that petitioner had no problems with her left shoulder until she was brushing her hair on 7/31/10.

On 3/8/10 petitioner had a repeat left shoulder MRI that showed her tendinopathy had continued to improve.

Despite this improvement, on 4/12/11 petitioner completed a Leave of Absence Application requesting a leave from 4/11/11 through 4/30/11 for medical leave that was non-work related. This leave was ultimately extended through 4/16/12. Petitioner signed this Application.

After Dr. Sanchez-Sotelo drafted a letter to petitioner denying her request for a letter that would state she could not drive because of her chronic use of Vicodin, given the fact that Dr. Sanchez-Sotelo did not believe that her shoulders justified continued use of Vicodin, petitioner sought treatment for her left shoulder from a different healthcare provider, Dr. Collins, on 5/12/11. Petitioner gave Dr. Collins a history that her left shoulder pain was caused from over use of the left arm following surgery on the right shoulder 4 months ago. The arbitrator finds this history inconsistent with the credible medical records that show petitioner had surgery on her right shoulder about a year and a half prior on 11/13/09. She then goes on to state that the onset of her left shoulder problems was on 7/31/10, which the arbitrator notes was the date she had an insidious onset of pain in her left shoulder while she was combing her hair. Petitioner then stated that she lifts 30 pounds or more a lot at work. However, she failed to offer any details regarding her job duties, nor did she provide a job description to support this claim. In fact, the arbitrator notes that the petitioner had previously reported that she really did not know how her left shoulder problems came about at work. She only had left shoulder complaints when she was brushing her hair on 7/31/10 and again on 8/7/10. For these reasons, the arbitrator finds the history petitioner provided Dr. Collins to be inconsistent with the credible evidence.

Following her left shoulder surgery on 7/27/11 petitioner underwent a course of physical therapy. At her Initial Evaluation on 9/30/11 she gave yet another history of the onset of her left shoulder symptomatology. Petitioner reported to her therapist that her left shoulder problems only started while working full duty in early 2011. The arbitrator finds this would put the onset of her left shoulder complaints at about 6 months after her alleged accident date.

The arbitrator finds this accident history inconsistent with the letter petitioner drafted on 8/9/10, and the Employee Injury/Illness Report she drafted that same day, in which she reported 2 very specific onsets of left shoulder pain on 7/31/10, and 8/7/10 while brushing her hair. Petitioner specifically alleged that this was the first time she noticed any problems with her left shoulder. Based on these very specific claims, the arbitrator find the petitioner's further claims that she "thought" her left arm symptoms were due to the fact that she did not use her right arm for several months, or the possibility that she injured her left shoulder when she injured her right shoulder, to be without merit. The arbitrator also finds it significant that although petitioner repeatedly testified that she reported this alleged left shoulder injury to her supervisor, she could not recall who she reported to, or when she reported it.

Given the fact that the burden is on the petitioner to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder that arose out of and in the course of her employment by respondent on 7/31/10, the arbitrator finds the petitioner has failed meet this burden of proof. The arbitrator finds the accident history provided in her testimony, her documented reports and letters, and what she reported to her various healthcare providers was inconsistent, and cannot be relied on. With respect to the alleged accident date of 7/31/10, the arbitrator finds the only thing that happened on that day, which petitioner specifically alleged in her letter of 8/9/10, was that she had an immediate onset of pain in her left shoulder when she went to brush her hair on 7/31/10 that lasted about 10-15 minutes. The arbitrator also finds it significant that on 7/8/10 petitioner reported that she participates in multiple recreational activities that include throwing a ball, shooting a basketball, and dribbling a basketball, and specifically reported difficulties with these activities, but not her work activities.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm.

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

10 WC 21755 - Right shoulder injury

This issue is not in dispute with respect to this claim. The parties stipulated that petitioner's current condition of ill-being as it relates to her right shoulder is causally connected to the injury she sustained on 6/22/09.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue moot.

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?

10 WC 21755 - Right shoulder injury

This issue is not in dispute with respect to this claim.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue moot.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

10 WC 21755 - Right shoulder injury

The parties have stipulated that the petitioner was temporarily totally disabled from 11/13/09-2/28/10, a period of 15-3/7 weeks. The respondent has paid the petitioner $10,995.02 in temporary total disability benefits, and $712.88 in temporary partial disability benefits.

The petitioner is claiming she is entitled to maintenance benefits from 7/14/14 to 8/1/15, a period of 54-5/7 weeks. Respondent denies that petitioner is entitled to any maintenance benefits.

Following petitioner's surgery to her right shoulder on 11/13/09 petitioner was returned to light duty work on 2/28/10. At first, she was restricted from any use of the right upper extremity. On 4/18/10 she was restricted from lifting no greater than 25 pounds in the right hand. On 5/18/10 Dr. Sanchez-Sotelo again restricted petitioner from lifting over 25 pounds. He was of the opinion that petitioner could perform repetitive motion work, and work 12 hour shifts. Petitioner testified that she returned to work, and at times performed lifting in excess of her restrictions, but never provided any specific evidence of this.

On 9/20/10 Dr. Sanchez-Sotelo examined petitioner and noted that her right shoulder seemed to be doing quite well. On 11/22/10 Dr. Sanchez-Sotelo drafted a letter to petitioner informing her that her right shoulder was completely healed and she did not have permanent restrictions in terms of lifting. Petitioner continued in physical therapy.

On 1/3/11 Dr. Sanchez-Sotelo noted that he did not think petitioner could lift 60 to 100 pounds in the future. He also noted that a repeat MRI of the right shoulder showed her previous repair was healed, tendinopathy of the supraspinatus. He was of the opinion that it looked like the deeper portion of the supraspinatus had retracted to the level of the midportion of the humeral head. Dr. Sanchez-Sotelo's diagnosis was persistent pain in the right shoulder with a previous subscapularis/supraspinatus repair with evidence of a partial recurrence of the supraspintus tearing on the articular side of the joint.

On 3/29/11 and 3/30/11 petitioner underwent a FCE. A formal job comparison could not be completed since a job description was not available for her position. However, based solely on petitioner's history that if

the line breaks down she must help with the manor labor which could require 60-100 pounds of weight handling, the evaluator was of the opinion that the petitioner's physical abilities would not match her claim if she would need to do 60-100 pounds of weight lifting. The results of the FCE showed that petitioner demonstrated the ability to statically push 70 pounds, and pull 80 pounds; the ability to lift floor to waist 20 pounds, occasionally (heavy level); ability to lift overhead up to 15 pounds, occasionally (heavy level); the ability to carry up to 20 pounds, occasionally (heavy level); the ability to carry with the right upper extremity up to 15 pounds, occasionally (heavy level); and the ability to carry with the left upper extremity up to 20 pounds, occasionally (heavy level).

On 4/12/11 petitioner went off work for a non-work related medical leave. On 4/26/11 and 5/10/11Dr. Sanchez-Sotelo drafted letters to petitioner informing her that he could not envision any further treatment that would help her right shoulder. On 5/21/11 Dr. Sanchez-Sotelo signed a form indicating that petitioner was at MMI with permanent restrictions as determined by the FCE.

While on her non-work related medical leave that was extended 9 times through 4/16/12, petitioner treated for her left shoulder, including surgery on 7/27/11. Following surgery petitioner complained of many left upper extremity problems that Dr. Collins had no medical explanation for, despite various diagnostic tests, that came back normal. Petitioner was ultimately released from care by Dr. Collins on 1/6/12. He released petitioner to full duty work without restrictions for her left shoulder.

After her non-work related medical leave ended on 4/16/12 petitioner was returned to work with permanent restrictions, on the 2nd shift, which was 2:30 pm-2:00am. Petitioner was not happy on this shift because she did not see her kids often. Petitioner testified that her job duties were the same as they were before her accident. Petitioner's duties as a supervisor were to make sure team members knew the specifics of products, made sure the orders were met, make sure yields were there, held safety meetings, and ensure quality for the customers. Petitioner worked in this position without incident for 2 years. However, since she did not like working the 2nd shift, she began putting in for jobs in other departments. It was petitioner's own decision to look for alternate employment due to personal reasons.

Petitioner was ultimately transferred to a Safety Management Position in Wisconsin in March of 2014. This was a job petitioner had applied for. Petitioner testified that she made more money in this position, approximately $2,000 more a year. Petitioner remained in this position until 7/14/14 when she, and other employees at that plant, were placed on a permanent layoff. Other employees were told to apply for other jobs, and were transferred to other states. Petitioner refused to apply for the job in Nebraska that respondent told her to apply for, based on the recommendation of her attorney, and her husband. The arbitrator finds it significant

that although she would not apply for the job in Nebraska that respondent recommended she apply for, she had no trouble applying on her own for jobs as far away as New Jersey and Pennsylvania.

For these reasons the arbitrator finds the petitioner is not entitled to any maintenance benefits. It is unrebutted that respondent returned petitioner to work in a supervisory position, similar to the one she had before the accident, that accommodated her permanent restrictions. However, since she did not want to work the 2nd shift she ultimately transferred out of that position 2 years later at her own request.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue moot.

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

10 WC 21755 - Right shoulder injury

Petitioner is alleging that she is entitled to a wage differential pursuant to Sections 8(d)1 of the Act for the injuries sustained to her right upper extremity. In order receive this award of permanent partial disability the petitioner must meet the burden of proof required to demonstrate that the disability caused an impairment of earning capacity unless the petitioner waives her right to an award under Section 8(d)1 of the Act.

Section 8(d)1 of the Workers' Compensation Act deals with the employee who sustains an accidental injury and as a result becomes partially incapacitated from pursuing her usual and customary line of employment. Additionally, if the employee has permanently reduced earnings as a result of the disability, compensation can be awarded based on a percentage of the difference between the average amount the employee earned before the accident and the average amount the employee is earning or is able to earn in some suitable employment or business after the accident.

Petitioner served in a supervisory capacity at the time of her injury and returned to a supervisory position after her injury, which was within her permanent restrictions. The supervisory position she was returned to was on the 2nd shift. Thereafter, petitioner became unhappy working the 2nd shift, and as a result, she applied for various other jobs with respondent and was ultimately transferred to a Safety Management Position in Jefferson, WI. in March of 2014. In this new position petitioner received an increase in wages. The arbitrator finds it significant that although the petitioner repeatedly claimed that she was required to perform work in excess of her restrictions in her new supervisory position, she provided no specific details regarding when this occurred, the alleged supervisors she reported this to, and when she reported these instances to them. Additionally, the

petitioner failed to offer into evidence a job description for the job she was returned to after she was placed on permanent restrictions. For these reasons, the arbitrator finds the petitioner's testimony that she transferred positions because she did not see her kids enough when she worked the 2nd shift is more persuasive than her claims of performing work outside her permanent restrictions.

In July of 2014 petitioner, and many other employees in the Jefferson, WI plant, where petitioner was working at that time, were laid off permanently. When this occurred, respondent recommended that petitioner apply for a job with respondent in Nebraska. Respondent also recommended other out of state positions for other employees who were permanently laid off. Petitioner refused to apply for this job at the direction of her attorney and her husband. Instead, she began looking for jobs on her own. Her job search log shows that although she would not apply for the position respondent recommended in their Nebraska plant, she had no problem applying on her own for jobs as far away as New Jersey and Pennsylvania.

Although petitioner graduated from American Intercontinental University in 2009, and got her Masters Degree in Business Administration and Human Resources in 2012, she ultimately took a job as a sales consultant with LuJack Auto Sales on 8/2/15. From 7/14-8/15 petitioner's job log only shows that she applied for 52 jobs, with more than half of them being with respondent, but never applying for the job respondent recommended she apply for. The arbitrator finds it significant that in over a year period, the petitioner averaged less than 1 job search a week, and in reality when long periods of time without even looking for a job.

Petitioner testified that she earned $44,000 working for LuJack in 2016. However, the only evidence she offered with respect to this claim was a few paychecks she received from 10/16/16 through 12/31/16, despite the fact that she worked for LuJack from August of 2015 to present. Petitioner only provided paychecks for the last 2 1/2 months of paychecks 2016, and did not provide any W-2 for 2016 that would have shown her actual earnings for 2016. Additionally, with respect to 2017, petitioner did not provide any evidence of what she was earning.

Based on the above, the arbitrator finds the petitioner has failed to prove all the elements of a wage differential pursuant to Section 8(a) of the Act. First and foremost, the arbitrator finds that when the petitioner returned to work for respondent with permanent restrictions she was placed in a supervisory role, which was her usual and customary line of employment with respondent. At no time while in that position did petitioner present credible evidence to show that she was unable to pursue this line of employment. In fact, it was the petitioner who testified that she decided to look for alternate employment because she did not like working the second shift. The arbitrator finds this testimony supports a finding that petitioner left her usual and customary line of employment after her injury solely due to personal reasons.

Additionally, the arbitrator finds the petitioner has failed to prove by the preponderance of the credible evidence that her earnings were permanently reduced as a result of the disability. First, the arbitrator finds that when petitioner was returned to work with permanent restrictions, in her usual and customary line of employment, she offered no evidence to support a finding that her earnings were reduced. In fact, when petitioner voluntarily left this supervisory position to take to the Staff Management Position in Jefferson, WI, her wages actually increased by another $2,000 a year.

Assuming arguendo, one was to look at petitioner's job at LuJack to determine if petitioner's earnings were permanently reduced, the arbitrator finds the petitioner has failed to provide sufficient evidence to prove this element of her claim. The petitioner testified that she has worked for Lujack since August of 2015, a period of about a year and a half. However, what petitioner has actually earned during that period, or is currently earning today, is unknown, based on the fact that petitioner has failed to offer any evidence to support this claim. Petitioner only saw fit to enter into evidence a few payroll stubs from the October-December of 2016 in support of her claim. The arbitrator finds these select paystubs are insufficient evidence to support a claim that her earnings are permanently reduced. Petitioner failed to offer into evidence any payroll stubs for the period August 2015-September 2016, or any payroll stubs from 2017. For these reasons, the arbitrator finds the petitioner has failed to show that her earnings have been permanently reduced.

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she is entitled to a wage differential pursuant to Section 8(d)1 of the Act, the arbitrator finds the petitioner is entitled to a permanent partial disability pursuant to Section 8(d)2 of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, petitioner was a supervisor for respondent. In April of 2012, following treatment for her left shoulder, petitioner was released with permanent restrictions with respect to her right shoulder, and full duty with respect to her left shoulder. Petitioner was returned to her usual and customary line of employment as a supervisor for respondent, albeit on the 2nd shift. At some point while working as a supervisor on the 2nd shift petitioner decided that she did not like working the 2nd shift because she did not see enough of her kids. For this reason, petitioner began applying for alternate jobs with respondent and two years later, in April of 2014, petitioner transferred to a better paying job for respondent in a Safety Management Position in Jefferson, WI. Based on this evidence the arbitrator finds the petitioner was able to continue working in her usual and customary line of employment as a supervisor with

permanent restrictions, until she decided for personal reasons she no longer no wanted to continue her usual and customary line of employment for respondent. Based on these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 44 years old at the time of the accident. After the accident, petitioner was returned to her usual and customary line of employment as a supervisor for respondent, with permanent restrictions. Petitioner worked in this capacity for 2 years without any documented complaints, until transferring to a better paying job for respondent where she could work a different shift. When petitioner was permanently laid off from this position she was told to apply for a different position with respondent, as were other employees at that location who were permanently laid off. However, petitioner declined and began her own job search. Although petitioner has a Bachelor's degree from American Intercontinental University, and a Masters Degree in Business Administration and Human Resources, petitioner has chosen to work for LuJack as a sales consultant. Based on these facts, 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 finds the petitioner's evidence with respect to her future earnings was scant as best. For the year and half she has worked for LuJack she only decided to offer into evidence two months of payroll stubs, that were not her most recent. It is unclear why petitioner did not offer into evidence her most current payroll evidence from LuJack. Because of this the Arbitrator therefore gives little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator adopts the findings and opinions of the FCE performed on 3/29/11 and 3/30/11, and adopted by Dr. Sanchez-Sotelo. As a result of the FCE petitioner demonstrated the ability to statically push 70 pounds and pull 80 pounds; ability to lift floor to waist 20 pounds, occasionally (heavy level); ability to lift overhead up to 15 pounds, occasionally (heavy level); ability to carry up to 20 pounds, occasionally (heavy level); ability to carry with the right upper extremity up to 15 pounds, occasionally (heavy level); ability to carry with the left upper extremity up to 20 pounds, occasionally (heavy level). Because of this 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 a permanent partial disability to the extent of 37.5% loss of use of her person as a whole, pursuant to §8(d)2 of the Act.

11 WC 45991- Alleged left shoulder injury

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left shoulder on 7/31/10 due to "overuse" of her left shoulder while working for respondent with restrictions on her right arm, the arbitrator finds this issue 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

Denise Andrews,

Petitioner,

vs. NO: 16WC 17551

Rush Oak Park Hospital ,

Respondent.

18IWCC0546

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, 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 October 3, 2017, is hereby affirmed and adopted.

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

18IWCC0546

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.

SEP 5 - 2018

DATED:
o082818
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

ANDREWS, DENISE
Employee/Petitioner

Case# **16WC017551**

RUSH OAK PARK HOSPITAL
Employer/Respondent

18IWCC0546

On 10/3/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.19% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
10 S DEARBORN ST SUITE 500
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
GAIL BEMBNISTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DENISE ANDREWS,
Employee/Petitioner

v.

RUSH OAK PARK HOSPITAL,
Employer/Respondent

Case # 16 WC 17551

Consolidated cases: ----

18IWCC0546

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 11, 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, **4/22/2016**, 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 **$95,108.00**; the average weekly wage was **$1,829.00**.

On the date of accident, Petitioner was **59** 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 **$7,064.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$7,064.00**.

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

ORDER

The Arbitrator concludes Petitioner proved by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by Respondent on April 22, 2016.

The Arbitrator concludes that Petitioner failed to prove by a preponderance of the credible evidence that her current condition of -ill being is causally connected to her injury of April 22, 2016.

Because the Arbitrator found that Petitioner's current condition of ill-being was not causally connected to her injury, Petitioner request for relief pursuant to Sections 8(a), 8(b) and request for prospective medical care is hereby denied.

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

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

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

Signature of Arbitrator

10/2/2017
Date

ICArbDec19(b)

OCT 3 - 2017

PROCEDURAL HISTORY

The case proceeded to trial on September 11, 2017 pursuant to Section 19(b) of the Act. The parties stipulated that Petitioner, Denise Andrews, and Respondent, Rush Oak Park Hospital, were operating under the Illinois Worker's Compensation Act and their relationship was employee and employer. The Parties further stipulated to notice of the accident and that Petitioner's earnings during the year preceding the injury were $95,108.00 and Petitioner's average weekly wage was $1,829.00 pursuant to Section 10 of the Act. Respondent disputes that Petitioner sustained an accidental injury that arose out of and in the course of her employment by Respondent, that Petitioner's current condition of ill-being is causally connected to a work injury, that Respondent is liable for unpaid medical bills, that Petitioner is entitled to 51 6/7ths weeks of TTD benefits and that Petitioner is entitled to prospective medical treatment.

FINDINGS OF FACT

Petitioner, who is 60 years of age, was employed by Respondent for fourteen years as a registered nurse who worked in the emergency room. Petitioner testified that on April 22, 2016, she was transporting a patient in a wheelchair when she felt a pull in her back. Petitioner testified that she did not immediately seek medical treatment because she thought she pulled a muscle so she self-treated using a back brace and portable TENS unit.

A document entitled a Report of Injury/Exposure was submitted into evidence. (PX 1, RX 3) The Report of Injury form indicates that Petitioner sustained an injury to her lower back while pushing a 400-pound patient in a wheel chair on April 22, 2016. The Report of Injury form was signed by Petitioner's supervisor states that the employee does not want treatment, refused to consent to treatment and refused to fill out the Report of Injury form. (PX 1, RX 3)

On June 1, 2016, Petitioner sought medical treatment. Petitioner testified she received treatment at Rush and she had an MRI. On June 1, 2016, Petitioner was treated at Elmwood Park Same Day Surgery Center. Petitioner reported developing low back pain at work on 21st of April while pushing a patient in a wheelchair. Petitioner reported pain off and on since that date and she had been taking Advil. Petitioner reported that she is now having radicular pain. Petitioner reported her pain level as 8-9 out of 10. Petitioner further reported that she had been using a back brace and taking ibuprofen for pain for two weeks but, this week, she started to experience pain radiating down her legs, numbness and tingling. The medical records indicate Petitioner has a recurrent problem and the current episode started more than 1 week ago. The MRI report found degenerative lumbar levoscoliosis centered at L3-L4 with right lateral subluxation of L3 over L4, degenerative disc/endplate

changes and facet arthropathy at multiple levels in the lumbar spine and varying degrees of foraminal stenosis between L3-L3 and L5-S1. Petitioner was given Flexeril and she was referred to a specialist. (PX 2)

On June 9, 2016, Petitioner presented herself to Dr. Singh of Midwest Orthopedics at Rush. Petitioner reported that on April 21, 2016, she was pushing a patient in a wheelchair when she immediate low back pain and she was taken off duty. Petitioner testified she was not taken off work until Dr. Singh took her off work on the 9th of June. Dr. Singh diagnosed degenerative lumbar spondylosis, proscribed physical therapy and issued light duty restrictions. Petitioner reported her pain level to be 6 out of 10. Dr. Singh's examination noted that Petitioner had a negative Hoffman's test, negative Spurling's sign and negative inverted Brachioradialis findings. Petitioner's patellar and achilles reflexes were 2+ on both the right and left and her motor quad strength was 5 on both the right and left sides. Dr. Singh's assessment was degenerative lumbar spondylosis. (PX3)

On June 28, 2016, Petitioner returned to Elmwood Park Same Day Surgery Center. Petitioner reported diffused back pain, on both sides, numbness and tingling going down both legs. Petitioner reported that she was working light duty. Petitioner was proscribed and given epidural steroid injections at L3-L4. (PX 2)

On June 30, 2016, Petitioner returned to Dr. Singh. Petitioner reported low back pain with bilateral feet numbness and tingling. Petitioner indicated that her pain level was 7-8 out of 10 and she was experiencing bilateral leg heaviness and weakness with ambulating stairs. Dr. Singh performed an examination. Petitioner's quad strength was 5- on both the right and left sides and her hip flexor was 4+/5- on both the right and left sides. Dr. Singh diagnosed degenerative scoliosis L3-S1 and recommended surgery consisting of L3-4, L4-5 XLIF with lumbar instrumented posterior spinal fusion from L3 to S1. (PX3)

On July 14, 2016, Petitioner returned to Dr. Singh. Petitioner reported that her back-pain level was 8 out of 10 and that she was having intermittent right anterior thigh numbness and tingling with pain which ends at the knee. Petitioner also reported weakness with ambulating and climbing stairs. Dr. Singh found that Petitioner's left and right quad strength was 5-, negative Hoffman test, negative Spuling's test, negative inverted brachioradialis test. Dr. Singh maintained Petitioner's light duty restrictions and ordered Petitioner to undergo pre-operative workups. (PX 3)

On August 10, 2016, Petitioner was examined by Dr. Andrew Zelby, pursuant to Section 12 of the Act. Petitioner reported that she felt pain in low back and thought she pulled a muscle after pushing a patient in a wheelchair on April 22, 2016. Petitioner reported after a few weeks, one morning, around the beginning of June, she began to experience numbness and tingling from her waist down circumferentially through both lower extremities. Petitioner said she has constant low back pain and, sometimes, her legs feel wobbly and unsteady. Petitioner told Dr. Zelby the numbness and tingling went away about 1-2 weeks after it began but now she has a

sensation of tingling that starts a little bit above her ankles and goes circumferentially down through the entire aspects of both feet. (RX 1, Dep. Ex. 2)

Dr. Zelby examined Petitioner and found her lumbar range of motion to be normal, the lying straight leg test was negative and the sitting leg raise test was negative. Petitioner's toe and heel walk was normal. Petitioner had a normal spine, normal neurologic exam and Petitioner had no radicular symptoms. Dr. Zelby noted that Petitioner had gait difficulties but with no neurologic bases. Dr. Zelby found that Petitioner's reflexes were normal except for diminished but symmetric archilles reflexes and toes that were down going bilaterally. Dr. Zelby noted that Petitioner was making inconsistent behavioral response positive for pain on superficial light touches. (RX 1, pgs. 13, 14) Dr. Zelby diagnosed Petitioner with lumbosacral spondylosis without radiculopathy and low back pain. (PX 1, pg. 18)

Dr. Zelby testified that Petitioner did not have an onset of back pain at the time of the injury, Petitioner had transient back pain which resolved on the same day. Dr. Zelby testified that when Petitioner sought treatment five weeks later, she indicated her back pain started 3 weeks after the reported injury date. (RX 1, pg. 18). Dr. Zelby reviewed and compared Petitioner's 2016 MRI to her 2004 MRI. Dr. Zelby found no significant changes between the MRIs and Dr. Zelby did not find anything in Petitioner's 2016 MRI suggesting she had an injury or that she exacerbated or accelerated her pre-existing degenerative condition. (PX1, pg. 19) Dr. Zelby testified that Petitioner's current condition was exclusively related to the manifestations of a long-standing degenerative condition which was not affected, in any way, to the reported work injury in April of 2016. Dr. Zelby testified that if Petitioner's April 2016 work incident had caused her current severe back pain than the it should have been prominent within 24 to 48 hours of the injury and not weeks after the injury. (PX 1, pg. 20)

Dr. Zelby testified the recommended treatment is for a degenerative condition and no medical evidence suggesting the treatment was caused or made more likely to become necessary because of Petitioner's work injury or work activities. (RX 1, pg. 20) Dr. Zelby opined that Petitioner's current condition was exclusively related to manifestations of her degenerative condition and her smoking. (RX 1, pg. 21,22)

Dr. Singh testified that he agreed with Dr. Zelby regarding Petitioner's preexisting radiographic disease, lumbar spondylosis and diffused stenosis extending from L3-L1. Dr. Singh testified that he also agreed with Dr. Zelby that Petitioner's MRIs of 2004 and 2016 were unchanged. Dr. Singh disagreed with Dr. Zelby regarding the issue of causation.

Dr. Singh testified that Petitioner was fully functioning and she had full strength but, now, she has difficulties walking and standing. Dr. Singh testified this fact is a significant component of his belief that Petitioner's underlying condition was aggravated by Petitioner's work related injury. (PX 5, pg. 15) Dr. Singh testified that Petitioner was neurologically intact prior to her accident and, now, she has documented progression

of motor weakness and deficits. (PX 5, pg. 18) Dr. Singh testified Petitioner's work accident is a plausible mechanism for an aggravation of her underlying degenerative condition. (PX 5, pg. 18) Dr. Singh opines that Petitioner did not have a neurological deficit prior to the April 2016 work incident and, now, Petitioner has a worsening of the deficit which implies causal connection. (PX 5, pg. 32)

During cross examination, Dr. Singh acknowledged that Petitioner probably had back pain before the April 2016 incident because of her scoliosis. Dr. Singh also acknowledged that any event including something in one's daily activities could have been the triggering event. Dr. Singh further acknowledged that Petitioner's underlying condition could have been flared up by normal activities of daily living to the point of irreversibility. (PX 5, pg. 37)

Petitioner testified that she appeared at the Commission in May 2017. Petitioner agreed to seek an opinion of a third physician, agreeable to both parties. Petitioner agreed to be examined by Dr. Alexander Ghanayem, chairman of the Department of Orthopaedic Surgery & Rehabilitation and Director of the division of Spine Surgery at Loyola University Medical Center. Petitioner was examined on July 17, 2017. Petitioner reported to Dr. Ghanayem that she experienced back pain on April 23, 2016 after pushing a 400-pound patient in a wheelchair. Petitioner said it felt like a back strain and she took ibuprofen. Petitioner reported the pain became worse weeks later and, in June of 2016, she developed some balance issues. Petitioner told Dr. Ghanayem she hasn't worked since August of 2016. Dr. Ghanayem indicated that Petitioner did not report any radicular pain into the legs. The x-rays showed some degenerative changes and mild degenerative scoliosis. Dr. Ghanayem found Petitioner's balance was good with no kyphosis or no signification coronal imbalance was noted. The MRI showed degenerative changes from L3 to the sacrum and subtle narrowing and moderate stenosis. Dr. Ghanayem found that Petitioner's neurologic exam revealed no focal motor or sensory deficits, Clonus was absent, Babinski sign was absent and the straight leg raise was negative for radicular pain. Dr. Ghanayem noted that Petitioner walked with a very unsteady gait pattern. (PX 2)

In his report dated July 17, 2017, Dr. Ghanayem opined that Petitioner may have sustained a back sprain from pushing a wheelchair but her current subjective complaints of balance difficulties were not related to her work injury and were not related to any structural findings on Petitioner's June of 2016 lumbar MRI. Dr. Ghanaym found Dr. Singh's causal connection opinion to be unfounded. Dr. Ghanaym found that Petitioner's gait disturbance and balance difficulties could not come from her lumbar spine. Dr. Ghanayem noted that something else was going on from either a neurologic standpoint or neurologic psychosomatic standpoint that is causing Petitioner's balance dysfunction is unrelated to her employment. (RX 2)

Dr. Ghanayem opined that Petitioner sustained a back sprain for which she was able to return to her usual job activities until much later in time when her symptoms became worse thus breaking the issue of causal connection. Dr. Ghanayem further opined that Petitioner sustained a back sprain that was short lived without any residual disability and that Petitioner reached MMI a few weeks after her back sprain and, relative to her work injury, Petitioner should be able to return ack to work at regular duty. (RX 2)

Upon the denial of further treatment, Petitioner has continued treatment at the Jesse Brown VA Medical Center. (PX 4) The Arbitrator fount 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). Thus, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro supra.* "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd dist. 2000). 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). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where the employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982).

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

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes Petitioner has proven by a preponderance of the credible evidence that she sustained an accidental injury-that arose out of and in the course of her employment by Respondent on April 22, 2016. Petitioner testified she experienced back pain while pushing a patient in a wheelchair. A Report of Injury/Exposure form was signed by Petitioner's supervisor which acknowledged that Petitioner was working on April 22, 2016 and she experienced some pain in her low back while pushing a patient in a wheelchair. (PX 1, RX 3) Respondent did not proffer evidence to the contrary.

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

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill2d 30, 36-37. Even though an employee has a preexisting condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied if it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has not proven by a preponderance of the credible evidence that her current condition of ill-being is causally related to her work injury as set for the more fully below.

The Arbitrator finds the opinions of Dr. Ghanayem and Dr. Zelby to be more reliable than the opinion of Dr. Singh. Dr. Ghanayem opined Petitioner sustained a back sprain but her current subjective complaints are not related to her back strain and that Petitioner reached MMI soon after her work incident. Dr. Ghanayem found Dr. Singh's opinion regarding causal connection to be unfounded and that Petitioner's current complaints could not come from the lumbar spine. Dr. Ghanayem found that Petitioner's balance dysfunctions to be unrelated to her work injury.

Dr. Zelby opined that Petitioner's current condition exclusively related to the manifestations of a long-standing degenerative condition that was not affected, in any way, to the reported work injury of April 21, 2016.

(PX 1, pg. 20) Dr. Zelby reviewed Petitioner's 2016 MRI and 2004 MRI and found no significant changes and that the 2016 MRI did not show any injury, exacerbation or acceleration to Petitioner's pre-existing degenerative condition. (PX1, pg. 19)

Dr. Singh acknowledged that any event in one's daily activities could have been the triggering event that aggravated Petitioner's preexisting condition and Petitioner's current condition could have been the result of a flare up caused by normal activities of daily living to the point of it was irreversible. (PX 5, pg. 37). Dr. Singh testified that his opinion was based upon the fact that Petitioner was fully functioning and she had full strength but, now, she difficulties walking and standing. Dr. Singh testified this fact is a significant component of his belief that Petitioner's underlying condition was aggravated because of Petitioner's work related injury. (PX 5, pg. 15) Dr. Singh testified that Petitioner had not been working since the work incident and that Petitioner's work accident was a plausible mechanism to aggravate Petitioner's underlying degenerative condition. (PX 5, pg. 18) However, Petitioner testified that she continued to work full duty after the April 22, 2016 and she did not seek any medical attention until June 1, 2016. Dr. Singh did not proffer any other support for his causation opinion.

The Arbitrator finds that Petitioner sustained an accidental injury on April 22, 2016 but the injury was minor such that Petitioner did not need any medical treatment or miss any time from work after the April 22, 2016 injury. Although Petitioner had previously treated for a back injury and had a pre-existing condition, the complaints Petitioner had, if any, did not rise to the level requiring medical treatment or impairing Petitioner's ability to perform her job duties. Dr. Singh testified that, due to her scoliosis, Petitioner was probably already experiencing back pain. After the April 22, 2016, Petitioner's pain levels did not increase or change such that Petitioner needed medical treatment.

Petitioner continued working until June 1, 2016 when, at that time, she experienced a sudden onset of numbness and tingling. Dr. Ghanayem found the symptoms were not related to Petitioner's work accident or related to any spinal condition. Dr. Ghanayem thought Petitioner's current condition was either neurologic or neurologic psychosomatic and the current condition was unrelated to Petitioner's work incident of April 22, 2016. Dr. Zelby agreed with Dr. Ghanayem that Petitioner's current condition of ill-being was not related to her employment. Dr. Zelby testified that Petitioner's current condition of ill-being was exclusively related to the manifestation of Petitioner's pre-existing degenerative condition and smoking. (RX 1, pg. 21,22)

Petitioner reported to Dr. Zelby, one morning, around the beginning of June, she began to experience numbness and tingling from her waist down to her lower extremities. Petitioner told Dr. Zelby the numbness and tingling went away about 1-2 weeks after it began but now she has a sensation of tingling that starts a little bit above her ankles and goes circumferentially down through the entire aspects of both feet. (RX 1, Dep. Ex. 2) Petitioner told Dr. Ghanayem in June of 2016 she developed balance issues. On June 1, 2016, Petitioner went to

Elmwood Park Same Day Surgery Center and reported that this week, she started to experience pain radiating down her legs, numbness and tingling. The Elmwood Park Same Day Surgery Center medical records indicate Petitioner has a recurrent problem and the current episode started more than 1 week ago. (PX 2) The Report of Injury/Exposure indicates that on April 22, 2016, Petitioner did not want to seek any medical treatment and she refused to consent to treatment. (PX 1, RX 3)

The Arbitrator does not find Dr. Singh's causation opinion to be persuasive because Dr. Singh's opinion that Petitioner's work incident was a plausible mechanism that aggravated Petitioner's underlying degenerate condition. (PX 5, pg. 18) It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507 (First Dist. 2000). The Arbitrator finds that Dr. Singh's opinion is based upon conjecture. The Arbitrator finds that it is also plausible to infer Petitioner's activities of daily life was the triggering event that aggravated Petitioner's preexisting condition o that Petitioner's current condition of ill-being is the natural sequela processes of Petitioner's pre-existing condition.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the determination that Petitioner failed to establish her work accident was causally connected to her current condition of ill-being, the remaining issues of Respondent's liability pursuant to Section 8 of the Act is moot and, therefore, will not be reached by the Arbitrator. Accordingly, Petitioner's request for benefits is denied.

WITH RESPECT TO ISSUE (K), IS THE PETITIONER ENTITLED TO PROSPECTIVE MEDICAL CARE, THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator finding that Petitioner failed to establish that her current condition of ill-being is causally related to the injury, Petitioner request for prospective medical care is denied.

WITH RESPECT TO ISSUE (L), WHAT TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner seeks TTD benefits from June 7, 2016 through June 9, 2016, June 30, 2016 through July 14, 2016 and from September 29, 2016 through September 11, 2017. (Arb. Ex. #1) The Arbitrator found that Petitioner sustained a back sprain at work, on April 22, 2014, which resolved prior to June 7, 2016. Petitioner request TTD benefits while off work for a condition which is not causally related to her work injury. Accordingly, Petitioner's request is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Zamora,
Petitioner,
vs.

NO: 15WC 34752

Auto Nation,
Respondent.

18IWCC0547

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 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.

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: SEP 5 - 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ZAMORA, JOSE
Employee/Petitioner

Case# **15WC034752**

AUTO NATION
Employer/Respondent

18IWCC0547

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:

5106 LAW OFFICE OF ANSELMO DURAN PC
4440 S ASHLAND AVE
CHICAGO, IL 60609

2461 NYHAN BAMBRICK KINZIE & LOWRY
WILLIAM A LOWRY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

☐ 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

Jose Zamora
Employee/Petitioner

v.

Auto Nation
Employer/Respondent

Case # 15 WC 34752

Consolidated cases: ___

18IWCC0547

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 **Wheaton**, on **July 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

FINDINGS

On 6/12/15, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $53,995.76; the average weekly wage was $1,038.38.

On the date of accident, Petitioner was 45 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 $8,059.61 for TTD, $5,968.37 for TPD, $ for maintenance, and $ for other benefits, for a total credit of $14,027.98.

Respondent is entitled to a credit of $36,804.05 under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof on 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

8/29/17
Date

SEP - 5 2017

18IWCC0547

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim at the Illinois Workers' Compensation Commission alleging he sustained work injuries to his right arm and shoulder on June 12, 2015 when he slipped on stairs while working at Auto Nation (AX2). On his Application, Petitioner initially alleged that the accident occurred on June 13, 2015, however, Petitioner amended his Application at the time of trial to allege a date of accident on June 12, 2015 (AX1; AX2). Petitioner said that an assistant filled in the date of accident because he couldn't write. At the time of the accident, the Petitioner was 45 years old and an employee at Auto Nation for 14 years. He was employed as a detailed technician. His job required that he keep the cars clean.

Petitioner said that he started work at 7:00 a.m. on June 12, 2015. The accident occurred between 3:00 and 3:30 p.m. Petitioner had cleaned a car and took it to the second floor, which was part of his normal job duty. The alleged accident occurred as Petitioner was going down stairs from the second floor to return to his detailing job. Petitioner initially claimed that he was going fast down the stairs as he makes money according to the number of cars he finishes. Petitioner later said he was rushing a little bit down the stairs. Petitioner said that he slipped and went forward and grabbed the stair railing twisting his right shoulder.

Petitioner said that the stairs were wet or moist. In describing the stairs as wet, Petitioner claimed that the building was made of concrete and the stairs were "sweaty." Petitioner stated that the step has a piece of metal that "could have possibly caused him to slip." Petitioner denied that he saw any water on the stairs. Petitioner then said that the stairs "were a little bit moist; they were wet." He agreed that there was good lighting in the stairwell and he could see fine. Petitioner also stated that although the stairs are normally sweaty in the summer, this was the only time in 14 years working at Auto Nation that he slipped on the stairs.

Petitioner said that he immediately went to his supervisor, Omar, to report his injury. Omar allegedly told Petitioner that he could finish the shift or take the rest of the day off. As Petitioner's shift was ending in 30 minutes, he decided to go home and take medication for pain. Petitioner said he did not work the following day, which was Sunday. He said he put up with the pain. Although Petitioner later gave a medical history during his initial treatment on June 15, 2015 of being unable to lift or move his arm, Petitioner said that he worked on June 15th and sought medical treatment afterwards.

The Petitioner provided medical histories as to the cause of his right shoulder condition during his medical treatment. When Petitioner first sought treatment with Dr. Perez-Guerra on June 15, 2015, three days after the alleged accident, Petitioner gave a history of having right shoulder pain for a week with an inability to lift or move his entire right arm. Dr. Perez-Guerra's records also reflect "no history of trauma or injuries." (Rx.1).

Petitioner testified he told Dr. Perez-Guerra he fell at work, but the doctor was focused on what was wrong rather than asking questions. Petitioner denied that he told Dr. Perez-Guerra of pain for one week. He denied telling Dr. Perez-Guerra he had no history of injury or trauma. Petitioner said he told Dr. Perez-Guerra he fell at work.

Petitioner also gave a history of his right shoulder condition when he received treatment from Dr. Bhatt, Auto Nation's company physician on June 17, 2015. Petitioner said that he gave Dr. Bhatt the same history that he described at trial. According to the record, Petitioner gave a history of "getting off the stairs" when he fell but he grabbed hold of a metal rail with the right arm.

In discussing the alleged work injury during physical therapy treatment on June 18, 2015, Petitioner gave a date of injury of June 11, 2015 and claimed that the injury prevented him from working the next day. (Px.2).

When Petitioner was initially treated by Dr. Tu on July 7, 2015, he gave a history of shoulder injury claiming that as he was coming down the stairs, he slipped and as he fell, he grabbed the railing with his right arm, pulling on the right arm and falling down the stairs.

Petitioner later gave an accident history to Dr. Wolin, Auto Nation's IME physician on October 7, 2016 (Rx.6, p.8). Petitioner said it was foggy and the stairs were wet. Petitioner further told Dr. Wolin he slipped and fell forward, grabbed the railing with his right arm and his body twisted forward and into a wall (Rx.6, p.8).

Dr. Perez-Guerra initially diagnosed Petitioner with osteoarthritis and a sprain/strain to the shoulder. Dr. Perez-Guerra ordered an MRI of the shoulder. (Rx.1; Px.1). Petitioner underwent the MRI of the right shoulder. The results of the MRI revealed evidence of mild rotator cuff tendinopathy without full-thickness tear or tendon retraction, mild arthritic changes, and a very mild subcortical edema within the humeral head. (Rx.1; Px.1). Petitioner returned to Dr. Perez-Guerra on June 16, 2015. He was diagnosed with pain in the shoulder joint region and a sprain of the right shoulder. (Rx.1; Px.1).

Petitioner was then evaluated by Dr. Bhatt at Concentra on June 17, 2015. (Px.1). Dr. Bhatt examined the MRI of the shoulder noting that it revealed rotator cuff tendinopathy but did not reveal any tear. Dr. Bhatt diagnosed Petitioner with a rotator cuff strain for which he was prescribed medication, right arm sling and physical therapy. (Px.2).

Petitioner then underwent physical therapy and continued to receive follow-up treatment from Dr. Bhatt between June 18, 2015 and June 26, 2015. Dr. Bhatt diagnosed Petitioner with a rotator cuff strain. (Px.2).

Petitioner sought medical treatment from Dr. Tu on July 7, 2015. Based on his physical examination and reviewing of the MRI, Dr. Tu diagnosed the Petitioner with right shoulder impingement, as there was no evidence of a rotator cuff tear. Dr. Tu administered a cortisone injection. Further physical therapy was prescribed. (Px.2). On August 25, 2015, Dr. Tu noted the Petitioner's improvement had plateaued through conservative treatment. Dr. Tu recommended Petitioner undergo an arthroscopic subacromial decompression. (Px.2,3). Dr. Tu performed arthroscopic surgery on October 2, 2015. Dr. Tu performed an arthroscopic subacromial decompression and a distal clavicle excision. Dr. Tu's post-operative diagnosis consisted of right shoulder impingement and acromioclavicular joint arthropathy. Post-operatively, Dr. Tu recommended Petitioner continue with physical therapy. (Px.2).

About a week after surgery, Petitioner was involved in a motor vehicle accident. Petitioner's car was rear-ended. He was the first car of four cars involved in the accident. Petitioner said that he filed a lawsuit as a result of the motor vehicle accident. Petitioner described his injury stemming from the motor vehicle accident. He said that he hurt his back and neck. In regards to his right shoulder, he said he did not feel anything. Yet, Petitioner agreed that he sought treatment from Dr. Poepping at Dr. Tu's office after the motor vehicle accident and on October 22, 2015. The medical record from Dr. Poepping reflects the Petitioner's history of the motor vehicle accident, which exacerbated his right shoulder pain. Petitioner testified he may have told Dr. Poepping that the motor vehicle accident made his right shoulder pain worse, "perhaps a little bit." (Rx.2).

On October 23, 2015, Petitioner attended physical therapy for his right upper extremity. (Px.2). Petitioner advised the physical therapist that he has back pain due to the motor vehicle accident. Petitioner claimed he

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was unable to perform activities of daily living or recreational activities independently. (Rx.2). Petitioner also advised Dr. Tu on October 27, 2015 of the motor vehicle accident. (Px.2).

Petitioner returned to Dr. Tu on November 24, 2015 and complained of right shoulder pain, limited range of motion and back pain. (Rx.3). Petitioner was having limitations in his range of motion and significant shoulder pain; he felt that a majority of this was after his motor vehicle collision that occurred a week after his surgery. (Rx.3). Dr. Tu now diagnosed Petitioner with early adhesive capsulitis. Dr. Tu believed that Petitioner's lack of improvement was likely secondary to the motor vehicle collision. (Rx.3). Dr. Tu recommended aggressive physical therapy and prescribed medications. He also indicated that another cortisone injection may be required if symptoms persisted. (Rx.3).

In December 2015, Dr. Tu noted that Petitioner's right shoulder symptoms were improving with aggressive physical therapy. Dr. Tu recommended continuation of physical therapy for his shoulder. (Px.2,3). Petitioner again reported improving symptoms on January 19, 2016. However, Dr. Tu administered a cortisone injection due to limited range of motion and weakness. (Px.2,3).

On February 15, 2016, Petitioner received his last physical therapy treatment. It was a 72nd visit. (Px.2). Petitioner was noted to be progressing faster than expected. Petitioner then returned to Dr. Tu on March 1, 2016. At this time, Dr. Tu noted that Petitioner had resolving right shoulder adhesive capsulitis. Petitioner was released to return to regular duty work on March 2, 2016. (Px.3; Rx.4).

Petitioner returned to Dr. Tu on May 10, 2016 advising that he had resumed full duty work and denied any complaints. Petitioner was found to have reached maximum medical improvement. (Rx.5; Px.2).

During the course of this claim, Respondent did have the Petitioner undergo an independent medical evaluation with Dr. Preston Wolin on October 7, 2016. (Rx.6). In addition to giving Dr. Wolin his history of the alleged work injury (Supra, Rx.6, p.8), Petitioner also advised Dr. Wolin of his motor vehicle accident. Petitioner told Dr. Wolin that he was a belted driver when he was hit from behind which resulted in increased shoulder pain that eventually diminished. (Rx.6, p.8).

Based upon his examination, which included review of Petitioner's medical records, Dr. Wolin opined, within a reasonable degree of medical certainty, that there was no evidence for finding a causal relationship between his shoulder condition and the alleged work episode. (Rx.6, p.4,14). Dr. Wolin opined that he did not believe the Petitioner's right shoulder condition was causally related to the work injury because it was not noted in Dr. Perez-Guerra's medical note. (Rx.6, p.20). Dr. Wolin stated that when a history is taken by a physician you would expect the history would be reflected in the written report. (Rx.6, p.24). Dr. Wolin opined that since the original history given by Petitioner to his primary care physician reflected no history of injury, this history would take precedence, as it was the most contemporaneous. (Rx.6, Exh.2).

Dr. Wolin further opined that based upon his reading of the MRI, there was no frank evidence of pathology, no rotator cuff tear, labral tear, etc. (Rx.6, p.15). Dr. Wolin said that there was evidence of a little bursitis in the shoulder and it was difficult to determine how long it had been there. (Rx.6, p.15-16).

Dr. Wolin also opined that the Petitioner's post-operative physical therapy treatment was excessive. (Rx.6, p.14). Dr. Wolin further opined that the Petitioner's motor vehicle accident exacerbated his symptoms. It was a temporary event that prolonged treatment. (Rx.6, p.16).

As part of his independent medical evaluation on October 7, 2016, Dr. Wolin also performed an AMA impairment rating. Dr. Wolin is certified to perform impairment ratings. (Rx.6, p.16). After explaining the rating process, Dr. Wolin stated that Petitioner had an impairment rating for 3% loss of the upper extremity or 2% loss as a person. (Rx.6, p.18).

Petitioner testified at trial that his shoulder currently feels fine and that he is able to perform all his job duties

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the medical evidence. The Petitioner's evidence to prove an accident is insufficient on two fronts. First, the evidence is insufficient to establish Petitioner sustained a work injury on June 12, 2015 due to a slip and fall on Respondent's stairs. Second, the Petitioner failed to prove that there was any defects on the stairway to have resulted in the alleged slip and fall.

The evidence presented at trial to prove an accident occurring on June 12, 2015 is suspect for several reasons. Petitioner had initially filed this claim alleging the accident occurred on June 13, 2015 and the accident date was amended to June 12th, 2015 at the time of trial. Yet, Petitioner's account regarding the accident date fails to demonstrate the work accident occurred on June 12, 2015. Petitioner testified that after the accident he was unable to use his arm and spent the next day, his off day, Sunday, putting up with the pain. Taking judicial notice of the 2015 calendar, Sunday was on June 14, 2015. To compound issues regarding the date of accident, Petitioner gives a history of the work injury occurring on June 11, 2015 to the physical therapist, along with a history that the injury prevented him from working the next day or June 12, 2015, the date of the alleged accident. These facts therefore disprove the accident occurring on June 12, 2015, a Friday.

Further, despite the Petitioner's complaints of being unable to lift or move his arm, he proceeded to work on Monday, June 15, 2015 before seeking medical treatment. Petitioner's testimony is suspicious as to the severity of his symptoms due to the alleged work injury. If his testimony as to his inability to use his arm is to be believed, a question arises as to how he was able to work. Moreover, despite his testimony regarding the work injury and symptoms, there is no history of work injury when Petitioner initially treats with Dr. Perez-Guerra. Instead, Petitioner only gives a history of pain in his shoulder for a week and denies a history of trauma or injury. This lack of a history of a work injury during initial medical treatment further refutes Petitioner's claim that an accident occurred on June 12, 2015.

Compounding these factual inaccuracies regarding accident, are the inconsistencies in the Petitioner's account as to how the accident occurred. In his initial history to Dr. Blatt, Petitioner gave a history that he was "getting off" the stairs when he fell and grabbed the metal rail. He gave a history to Dr. Tu that when he slipped he grabbed the railing and "fell down the stairs". By the time Petitioner saw Dr. Wolin, he gave a history of grabbing a railing, twisting his body "into a wall".

In sum, Petitioner's failure to provide a history of a work injury during initial treatment along with the inconsistencies in his subsequent descriptions as to the accident and discrepancies as to the date of accident are insufficient to prove Petitioner sustained an accident on June 12, 2015.

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Finally, the facts presented at trial further fail to prove a defect in the stairway to explain Petitioner's alleged fall. Petitioner gave various descriptions as to potential causes for him to slip on the stairway. He described thestairway as potentially wet or moist, yet he agreed there was no water on the stairway. Petitioner later stated that the stairway was sweaty as the building was made of concrete. Petitioner further stated that the stairs were normally sweaty in summer. Nevertheless, Petitioner admitted that during his 14 years he had never slipped on the stairways other than the time of the alleged accident. Petitioner also gave a different version to Dr. Wolin claiming the weather was foggy and the stairs were wet.

Petitioner failed to produce any evidence as to the condition of the stairs or weather conditions to meet his burden. Moreover, the best the Petitioner could say was that the piece of metal on the stairs "could have possibly" caused my slipping. This statement constitutes conjecture as to the cause of his fall and is insufficient to impose liability on Respondent.

In total, the Petitioner's testimony and histories lack credibility to prove he sustained an accident arising out of his employment due to an unwitnessed fall on a stairway on June 12, 2015. Further, Petitioner failed to produce evidence to establish a defect on the stairway, a neutral risk, to establish he was exposed to a greater risk of injury. For these reasons, the Petitioner's claim is denied.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues a rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Bloodworth,

Petitioner,

vs.

NO: 15 WC 20026

18IWCC0548

General Dynamics,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, TTD, medical expenses and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator, for the reasons set forth below.

Findings of Fact

Petitioner testified that he began working for Respondent as an MCA adjustor at the end of August in 2004. (T.13). He indicated that in June of 2005 he began working in the mortars department where he worked until the end of 2011, or about 6-1/2 to 7 years. (T.13). He noted that he subsequently worked in the tank department for about five years before eventually returning to the mortars department in November of last year (2016). (T.14).

Petitioner agreed that he filed the present workers' compensation claim alleging bilateral carpal tunnel syndrome and a date of injury of 9/24/14. (T.14). He indicated that in 2014 his primary care physician was Dr. Jeffrey Parks at Logan Primary Care. (T.14-15). He agreed that he first visited Logan Primary Care specifically for his bilateral carpal tunnel syndrome on 7/31/14. (T.15). He also agreed that prior to that he had turned in several injury reports to Respondent complaining about numbness and tingling in his hands for many years. (T.15). However, he agreed that he never specifically went out of his way to seek treatment for these

complaints until 2014, although he conceded that he may have made complaints of numbness and tingling in his hands to medical doctors prior to 2014. (T.16).

A review of the medical records shows that Petitioner visited Dr. Roger Watters on 8/27/12 with complaints of tingling that "... first began 36 months [ago]. The onset of the tingling has been gradual. The tingling is getting worse. The patient describes the tingling as partial (NUMBNESS). The tingling affects the hands (BILATERAL). Associated features include: numbness." (RX3). It was also noted that Petitioner was working more hours and had gained weight. (RX3).

Almost two (2) years later, Petitioner visited Logan Primary Care Services on 7/31/14. At that time, Dr. Rachel L. Terrill recorded that the patient "C/o BL hand parasthesias, pain, grip loss that radiates up to elbow. States noticed this after starting job at [G]eneral [D]ynamics 10 years ago. Does a lot of repetitive movements daily." (PX2, RX3). On examination tenderness with bilateral hand grip was noted with strength equal and intact. (PX2, RX3). The assessment at that time included hypertension, obesity and bilateral hand pain and parasthesias. (PX2, RX3).

An EMG report dated 8/29/14 recorded that the patient was a "34 y/o male with c/o numbness in BUE in digits 2, 3, and 4 with pain in digits 1 and 5. Symptoms present for 5-6 years worsening over past couple of years." (PX2). The study was interpreted as evidencing "moderate bilateral median neuropathy at the wrist (carpal tunnel syndrome) affecting sensory and motor components. There is NO evidence noted on this examination of ulnar neuropathy at the elbow or cervical radiculopathy in the nerves/muscles that were tested." (PX2).

In a Logan Primary Care Services "Consults" note dated 9/12/14 Dr. Jeffery Parks referred Petitioner to an orthopedic surgeon given a diagnosis of "CTS that is moderate." (PX2).

In a General Dynamics "First Aid/Injury Report" signed and dated by Petitioner on 9/24/14, Mr. Bloodworth noted "pain & numbness in shoulder, elbows & hands" and an alleged date of occurrence of "7-13." (PX1). In a separate section of this report, nurse Tammy Thompson recorded complaints of "pain in both shoulders, both elbows & pain in thumbs & 5 fingers [with] numbness in middle fingers on both hands." (PX1).

In a General Dynamics "First Aid/Injury Report" signed and dated by Petitioner on 12/8/14, Mr. Bloodworth noted "continuation of symptoms from last visit" and an alleged date of occurrence of "6/2008." (PX1). Also in this report, nurse Thompson recorded complaints of "soreness L elbow – both hands sore tingling [decreased] grip – no specific injury." (PX1). Nurse Thompson went on to note "no swelling of L elbow or hands – on palpation difficult to pinpoint distinct area of soreness in Elbow – grip strong, color good." (PX1).

In a progress note dated 3/25/15, Dr. Terrill recorded that "[t]his 34 year old male presents for CTS BL hands. Had NCS completed in August, is ready for referral. Pain is getting pretty bad, now has trouble with L elbow." (RX3). Petitioner with diagnosed with carpal tunnel syndrome and referred to an orthopedic surgeon. (RX3).

Petitioner testified that he subsequently visited Dr. Steven Young at the Orthopaedic Institute of Southern Illinois in May of 2015. (T.17-18).

In a report dated 5/7/15, Dr. Young recorded that "[t]he patient is a 34-year-old right-hand dominant male who I am seeing in consultation at the request of Dr. Jeffrey Parks. The patient is referred here with complaints of numbness, tingling, and pain, bilateral upper extremities. His symptoms have been present since approximately 2008. He specifically states that repetitive use tends to bother him. Symptoms are worse while at work. He is employed at General Dynamics. He rates the severity of pain as a 7 on a scale of 1 to 10. Rest will allow the symptoms to improve somewhat. He has been to physical therapy without any substantial benefit." (PX3). Following his examination and review of the nerve conduction study, Dr. Young's assessment was bilateral carpal tunnel syndrome. (PX3). Dr. Young noted that he discussed treatment options with the patient and it was decided that "... surgical intervention is most likely to give the patient relief, as he has had symptoms for 5 to 6 years and is found to have moderate carpal tunnel syndrome. I believe the more conservative approach is unlikely to provide lasting benefit... [Petitioner] would like to proceed to carpal tunnel release. He will need to have both sides done, we will simply do one at a time. He would like to start with the left..." (PX3).

On 6/29/15, Petitioner underwent a left carpal tunnel release at the hands of Dr. Young. (PX3). Petitioner testified that he worked up to the date of surgery and did not return to work between the two procedures. (T.19-20).

In a progress report dated 7/14/15, Dr. Young noted that Petitioner was doing well two weeks and 1 day post-surgery, and that "... his symptoms of numbness and tingling have resolved and overall he is very happy with surgery. The patient continues to have numbness and tingling in the right side and he is inquiring about scheduling the right carpal tunnel release." (PX3). Petitioner was instructed to lift nothing greater than 5 pounds with the left upper extremity and was scheduled for a right carpal tunnel release. (PX3).

On 8/12/15, Petitioner underwent a right carpal tunnel release at the hands of Dr. Young. (PX3).

In a progress report dated 8/26/15, Dr. Young noted that Petitioner was two weeks post right carpal tunnel release, and that "[t]he patient has no complaints." (PX3). Dr. Young ordered no lifting over 5 pounds and instructed the patient to work on range of motion. (PX3). He was also told him to follow up in about a month for re-evaluation. (PX3).

On 9/9/15 Petitioner was discharged from occupational therapy with goals having been met. (PX3).

In a progress report dated 9/28/15, Dr. Young noted that "[t]he patient returns today stating her [sic] symptoms of numbness and tingling have resolved. The patient states that he is doing much better. Overall, he is very pleased with the surgery." (PX3). Upon examination, Dr. Young noted the ability to form a full fist and extend the digits past neutral in addition to full range of motion at the wrist, including flexion, extension, supination and pronation as well as

ulnar and radial deviation. (PX3). Dr. Young concluded that "[a]t this time, I believe the patient is doing very well. We will allow the patient to return to work without restrictions. We will check the patient back here in our clinic on an as-needed basis. He was instructed to continue massaging the incision." (PX3).

In a separate "Work Status and Restrictions" form dated 9/28/15, Dr. Young's physician assistant, Lauren Rennie, PAC, noted that Petitioner was discharged from formal care and may return to work without restrictions. (PX3).

Petitioner testified that "[a]fter the surgery, my hands felt great. All the numbness and tingling, the pain was gone. And the last several months, I get a little bit of tingling again, my hands start to cramp. But as far as overall, my hands feel great compared to what they were two years ago." (T.20-21). However, he noted that "I don't have the grip that I used to. It's just not there anymore. My wrists are weak. I can't support myself to do a push-up anymore." (T.21).

With respect to his job with Respondent, Petitioner noted that he always worked as an adjustor, as opposed to an inspector. (T.22). He indicated that when he worked in mortars from 2005 to late 2011 his shift was "[a]nywhere from 10 to 12 hours average." (T.22). He stated that the majority of the shifts he worked during that time were 10 to 12 hours long, six days a week. (T.22). He noted that at the time he was an "MCA", but that there's basically no difference between that and an "LCA." (T.23).

In describing the mortars job, Petitioner testified that "[b]asically, we load paper increments into a vibratory process." (T.23-24). He stated that the paper increments were "paper cases" of nitrocellulose infused paper that hold a ball propellant "... that is charged for a mortar valve." (T.24). He indicated that General Dynamics makes ammunition for the military. (T.24). He stated that at the time they were building 81 millimeter and 120 millimeter rounds, and that they would rotate between them. (T.24-25). He noted that back then he would make anywhere from 5,600 to 7,200 81-millimeter rounds in a 12-hour shift and approximately 5,600 of the 120-millimeter. (T.25). He testified that there were three different component parts involved in making those size rounds in mortars, including nitrocellulose cases, a ball propellant and a tabbing material comprised of the same material as the case. (T.25-26).

Petitioner testified that mortars can be broken down into "inside" and "outside" the bay. (T.26). He noted that "inside" the bay required the feeding of a paper case into a machine, specifically a vibratory bowl that "... vibrates the cases around spiral to make sure no parts are upside[-]down because they all have a fill hole on the top. They vibrate through the bowl and down a track to a pick and place, a stationary machine that just picks it up and puts it onto a scale, and then robots will feed the parts through automatically." (T.26-27). He indicated that his hands were touching this vibratory bowl during the process, and that "[i]t frequently jams. We have to clear jams. We also have to – it will run low, so we have to fill the line back up, so we're touching it constantly. It will probably jam 20 to 30 times a day on a good day." (T.27). He noted that they don't touch it [the paper cases, presumably] if they don't have to (i.e. unless it's jammed). (T.27-28). He also agreed that in making 5,600 rounds they would use 5,600 of these paper cases. (T.28). He noted that "[t]hey come in on a Styrofoam rail. We have to slide those off the rail, into the hopper." (T.28). He indicated that this would require forceful gripping

because "[a]t times they would ... stick, and we would actually have to forcibly push them off." (T.28-29). In summarizing this activity, Petitioner agreed that he experienced the vibration if the machine jammed, and then from time to time he would have to do forceful gripping because the paper would stick. (T.29). He also agreed that if everything was working exactly according to plan he wouldn't experience any vibration on his hands or any forceful gripping, at least during this part of the process. (T.29). He indicated robots would take them from one point and transfer them to another point, called Table 1, where the powder is weighed out and funneled into the case automatically. (T.29-30).

Petitioner testified that "[a]t the end of the line is where the inspector sits, and when the inspector breaks out, the adjustor has to sit there." (T.30). He noted that "... as they [parts] come out of the machine, you pick them up, and you will look at the part, check the front, flip it over, check the back and then flip it to the front – or to the back, check for the stencil and the seam to make sure it's good, and then look at the front again, and there's two, we call them the feet, make sure there's no dents or dings there all over the part. I do it with both hands. You grab two, it's a lot faster and a lot easier. One, two, there, four (witness indicating), and then put them on the cart." (T.31). He indicated that in performing this motion he would turn his palms up, then back down and rotate his wrist to inspect the front and back of the part. (T.32). He noted that you "[p]ick up the part, flip it over, check the backs. Flip them back together, back to back and check the back, and then turn them front to back and check the toes, the feet on them, and then you place them together and put them on a cart." (T.32-33).

Petitioner indicated that the "81's" weigh approximately 42 grams while the "120's" would weigh about 137 grams. (T.33). He agreed that they were not very heavy at all, and that it did not require a great amount of grip to keep hold of them. (T.33). He also agreed that he was doing two at a time, one in each hand. (T.33-34). He indicated that he was doing this around 5,600 times per 12-hour shift. (T.34).

As to his work "outside" the bay, Petitioner noted that they first have to build boxes. (T.35). He noted that on average he would build anywhere from 35 to 50 boxes in a 12-hour shift. (T.35). He testified that "[t]he boxes are cardboard. They come in flat, broken down. What we have to do is lay them on a roller belt, and we take a foam roller and roll on a stencil nomenclature. And then we'll unfold the box and tape the bottom of it with two-inch tape and then a one-inch tape perpendicular. And then we have to take an explosive sticker and place it on the top flap of the box, and then we'll stack those boxes for use later." (T.35-36).

He also noted that "[o]ne other job that we do that I would call hand intensive is vacuum sealing the boxes. The boxes that are packed out inside the bay, after they're all screened, come out to the sealing area where we flip it up on end, we hit the corners – we bump the corners with a mallet so that they don't tear the bag, and then we take a vapor barrier bag and place it over the box, lay the box back down on its bottom and then push it as far back as we can get it. Then we run it through a sealing device that seals the open end and leave about a two or three-inch gap at one end. We suck out the air with a vacuum and then seal that little bit, too. Then we take and we smooth the bag out as good as we can and then tape with masking tape all the excess material so it will fit down inside of the box." (T.36-37). He described the bag as plastic, but noted that "... it's not stretching it over. It's a vacuum sealed bag so it's a loose open bag... We slide it

down. What gets labor intensive is when we have to flip the box back and forth." (T.37). He stated that the box at this point, that he's flipping around, weighs approximately 72 pounds. (T.37-38). He agreed that in order to flip that box, it requires some forceful gripping. (T.38).

Petitioner indicated that after mortars he worked in the tank department for approximately five years. (T.45). He agreed that there are four processes with respect to the tank – namely, bonding, propellant fill, propellant load and chamber gauge. (T.38). As to bonding, Petitioner testified that "[w]e take two, again, nitrocellulose cases, and we glue them together and clamp them tight so we can build [a] 120 millimeter tank round." (T.39). He indicated that there are two buttons that have to be pressed. (T.39). He also agreed that there is twisting and locking in place involved in this process. (T.39). Petitioner testified that the projectile is "... basically, the war head" and that "[t]he projectile is placed into a carrier, a large aluminum apparatus, basically, and it has what we call an adaptor to it, a cardboard based piece of material, and it comes into our station at the bonding station. We place – we push a button and apply glue to the edge of that adaptor. We take a case, which is a nitrocellulose, and we put it onto a turntable and press a button, and it applies glue to the edge of it. Then we flip over the case and take a tool balancer and connect it to the base ..." (T.40). He noted that there was no twisting and snapping of the projectile in this process. (T.40). He also indicated the process he just described is shown on the video offered into evidence by Respondent. (T.40). Petitioner stated that there is no vibration in bonding, and that the only forceful gripping involved is "... when you're lifting the case and pulling the clamp." (T.41). He estimated that he would do this "... between 200, 250 [times a day] on a normal basis." (T.41).

Petitioner agreed that propellant load and propellant fill, while different tasks, are pretty much part and parcel of the same process. (T.40-41). He testified that "... propellant load is when we load propellant into the vacuum system. The vacuum system is comprised of a shaker that shakes the barrel so that a vacuum system can run the propellant through a screen system, getting all the foreign materials out of it, and then – or any foreign material that shouldn't be in it. And then that vibrates the powder through it, into a hopper, which is also vibrating so that the vacuum system can suck it up and into the load – or the fill area." (T.41-42). He agreed that part of that process is depicted in the video. (T.42). Petitioner indicated that he would have to carry a bucket of propellant weighing roughly 15 pounds from one location to another and then pour it into a hopper. (T.42-43). He noted that this would require a forceful grip because "... I don't want to drop it" and "... nobody wants to walk on propellant." (T.43). He agreed that the hoppers vibrate and that normally his hands are in contact with those hoppers, assuming the process is working the way it's supposed to. (T.43). He indicated that they have to do this "... to check and make sure it continues to vibrate, as well as the track, when it starts to get low, pieces of propellant will actually stay in the chute, so we have to knock those out of the chute... There's small holes up the chute." (T.44). He agreed that he can feel that happening. (T.44). He testified that if he was at that station all day his hands would be touching these vibrating hoppers for 8 hours during a 12-hour shift. (T.44). He noted that he would describe this vibration as "mild." (T.44-45).

With respect to chamber gauge, Petitioner noted that it is "... where we take a finished round, we weigh it to make sure it's not under weight or over weight overall, and then we pick it up and place it into the chamber gauge, which makes sure that the overall diameter and length

are the correct measurements." (T.45). He estimated that he would do roughly 200 to 250 of these during a 12-hour shift, depending on the round. (T.45-46). He agreed that there was forceful gripping and vibration involved in chamber gauge work, and that the rounds weigh anywhere from 42 to 72 pounds. (T.46). He also agreed that he would have to forcefully grip these rounds as he moved them from one location to another so that he doesn't drop them. (T.46). He noted that "[a]fter we chamber gauge it and it passes the chamber gauge, we'll pull it back out and carry it over to a skid, which is usually about 3 to 5 feet away, and we'll put it on a skid and put a lock on it and lock it down." (T.46-47). He agreed that a portion of this work is also depicted in the video. (T.47).

Petitioner indicated that he had seen the video, consisting of six separate scenes. (T.48). He agreed that the first scene depicts the propellant fill, and that he did this work when he was working in the tank department. (T.48). He agreed that the video shows a suction device moving a 55 gallon drum onto a stand. (T.48). He indicated that the stand and 55-gallon drum were vibrating. (T.48). He also agreed that the video shows somebody moving that stand, which is on wheels, to a different room where a tube (which is not vibrating) is placed in it. (T.48-49). He indicated that his hands would be in contact with that vibrating drum. (T.49). Petitioner testified that what is missing in this first scene, in terms of hand intensive gripping, is "[t]he entire back room… The second room where the drum is moved into is where I was explaining the vibration, the vibratory screens and the vibratory hopper. There's times when we've got to clear a jam of propellant, and you have to reach into that hopper and scoop it out, or we may have to clean out the screens, you've got to touch that." (T.50). In addition, Petitioner noted that "[w]e also have to download rounds from time to time. And to do that, except for the IME HE-T's, which are highly explosives [sic], we don't want to vibrate those, all the other rounds we have to vibrate the powder out, at least the majority of the powder. And then we have to pick them up, shake them back and forth to get the powder out of it." (T.50-51). However, he indicated that he would not have to do that often during a 12-hour shift. (T.51).

Petitioner noted that the second scene was a "fair" depiction of what goes on in bonding while noting that "[t]he speed is a lot slower than normal operation." (T.51-52). He testified that "I know at one point they were talking about on the videos, this is my own assumption, but the video that we see is a lot slower, so I'm assuming that's probably the video they were doing for training purposes." (T.52).

Petitioner noted that the third scene shows the chamber gauge job and that it "… looked complete, just slower." (T.52-53).

Petitioner noted the fourth scene depicted the propellant load job. (T.53). He testified that "[w]hat's not shown [in this scene] is when the hopper tips forward, the rounds actually – you turn on the vibrator for the rounds to vibrate, as well. So you have a massive vibration with the rounds and then a minute amount of vibration with the hopper." (T.53-54). He stated that you are not touching the rounds if you don't have to, but that you might from time to time. (T.54). He also indicated that depending on the round that they're building it takes "[b]etween two and a half and six minutes" for the hopper to empty while it's vibrating. (T.54). He agreed that he is doing that many times a day. (T.54). He also agreed that the whole job involves grabbing it, putting it in the hopper, waiting for those to empty and then doing it again, over and

over. (T.55).

Petitioner noted that he performed the tasks depicted in the final two scenes very little, so there was no use in talking about them. (T.55).

Petitioner testified that he is currently back working in mortars. (T.56). He indicated that there are no more robots but that they have added a different, smaller round (a 60-millimeter round) that they are still developing the line for. (T.56).

On cross, Petitioner indicated that the numbness and tingling started in his right hand; however, he could not recall when that began, or when it began in his left hand. (T.57-58). Petitioner agreed with the medical records if they show that on 8/27/12 he reported a gradual onset of tingling that first began about 36 months earlier, or about three years ago, so about 2009. (T.59). He also agreed that in 2012 the numbness and tingling continued to get worse. (T.59). He likewise agreed that he was never diagnosed with carpal tunnel syndrome prior to 2014, and that no doctor had recommended that he get a nerve conduction study prior to 2014. (T.59). In addition, he agreed that no doctor had referred him to a surgeon for carpal tunnel prior to 2014. (T.59-60). Similarly, he agreed that he had never filed a claim prior to 2014 for what he thought was carpal tunnel. (T.60).

Petitioner agreed that he has very big forearms and pretty big hands, and that that has always been true. (T.60). He also agreed that from 2012 until he had his surgery with Dr. Young he was probably gaining some weight each year. (T.60).

Petitioner agreed that his shifts could range from 8 to 12 hours, but noted that the majority of his shifts in mortars and tank were 10 to 12-hours. (T.61). However, he agreed that he has worked other shifts that were 8-hours. (T.61).

With respect to his mortars job "in bay", Petitioner noted that "[t]he hopper vibrates intermittently. It's on a time in the machine." (T.61-62). He agreed that there were times when he got to the hopper with his rounds to dump when it was not vibrating. (T.62). When asked whether he didn't actually physically grip the rim of the hopper but rather put his hands on the shells that were already in the hopper, which could be vibrating, and kind of move them around to get them through the holes, Petitioner responded: "Well, that would be true, except for the vibrating part that we touch is the bowl. There's the hopper, and then there's the bowl. Now when the jams happen, they're on the back side of the bowl, so I have to reach and steady myself with one hand, as I am reaching across the back side of the bowl because I cannot go around because it is gated, so I would have to stop the machine and go around, and they don't want us to do that." (T.62-63). He agreed that when the shells go into the bowl, the bowl may or may not be vibrating initially, and that at some point it begins to vibrate to get the shells through the holes, and that some do not go through the holes so he will use one hand to grab the bowl, which may or may not be vibrating, and use the other hand to help clear the jam. (T.63-64). He indicated that he had no idea as the time period when it was vibrating compared to when it was not. (T.64). He acknowledged, however, that there were times when he would move the shell casings around when it was not vibrating. (T.64).

With respect to the "outer bay", Petitioner indicated that he would disagree that a more accurate estimate of the weight of the boxes he built was somewhere between 6 and 35 pounds. (T.65). He also noted that "[t]ypically, since we have two adjustors, one adjustor does the inside work a day, and the other one does the outside work a day." (T.65). He indicated that normally he would work a full day either inside or outside and that "[s]ometimes, depending on the agreement of the adjustors" he would switch the next day. (T.65-66). Petitioner testified that during the first seven years or so that he worked in mortars he worked "inside" more, estimating that it was 75/25 inside during that period. (T.66).

Also on cross, Petitioner agreed that he worked in the tank department for about five years, and that he would perform all four of the different processes "at least once" during a given day. (T.66-67). He stated that they would typically rotate each process every two hours, and that he was never exposed to eight hours of vibration in one day in tank because he was rotating jobs; however, he noted that "... as I said before, if I were to be on that job for a 12-hour shift, I would assume 8 hours." (T.67). As to the propellant fill, Petitioner testified that he has to turn the hopper on to vibrate and that it is not vibrating when he walks over with the casings and dumps them in. (T.68). He agreed that he is not grabbing the hopper initially, but noted that he still has to reach around the hopper "... and touch it to make sure that it's still vibrating because it does stop intermittently because of an issue with it." (T.68-69). He agreed, however, that it's not something he holds onto, and that after he determines that it's vibrating he would take his hands off. (T.69).

As far as doing between 200 and 250 projectiles a day, Petitioner agreed that that was the total between two adjustors, so that by himself he was probably doing half that, or 100 to 125. (T.69-70). He also agreed that these were the bigger warheads. (T.70). When asked whether that job is done a little more slowly, given that you don't want to drop the projectiles, Petitioner replied: "[j]ob site goes the same way." (T.70). Petitioner also agreed that the lighter tank rounds weighed approximately 42 pounds, but he was under the impression that the heaviest were 72 pounds. (T.70-71). He indicated that he believed that there were possibly seven or eight different sized tank rounds. (T.71). He also thought that counsel's estimate of him doing about 150 rounds a day "... would be on the low end." (T.71). He noted as well that he believed that he would carry these "[m]aybe a total of 12 feet" – 8 or 9 feet before they're chamber gauged and 3 to 5 feet after. (T.72).

In addition, Petitioner agreed that once he set the vacuum on the barrels the vacuum does the work of picking it up and moving it, and that there is no vibration associated with that vacuum. (T.72-73). He also noted that the tower that he climbs is vibrating "[m]ild to moderate" and that he goes up and down those stairs "[a] minimum of three times, normally more." (T.73). He estimated that the number of stars to the very top was 25, but conceded that he did not go up to the top every time. (T.73).

Petitioner agreed that he told Dr. Young, and probably Dr. Rotman, that his symptoms continued to worsen every year up until the time of surgery. (T.74). He also agreed that he told Dr. Young, and maybe Dr. Rotman, that he felt the mortar job was more repetitive than the tank job. (T.74). Similarly, he agreed that if he did a less repetitive job his symptoms continued to worsen. (T.74).

On re-direct, Petitioner agreed that the nerve conduction study he had in 2014 was actually the second one, and that his first one was done as part of his hiring process with General Dynamics. (T.75).

Board certified orthopedic surgeon Dr. Young testified that he initially saw Petitioner on 5/7/15 pursuant to a referral by Dr. Jeffrey Parks, a local primary care physician. (PX5, p.4). Upon physical examination at that time he noted a positive bilateral median nerve flexion compression test and Tinel's, but found negative provocative signs for cubital tunnel. (PX5, pp.5-6). A nerve conduction study performed by Dr. Terrance Glennon found moderate bilateral carpal tunnel syndrome. (PX5, p.6). Dr. Young's diagnosis was bilateral carpal tunnel syndrome. (PX5, p.6). Dr. Young discussed treatment options with the patient and "[w]e felt that surgical intervention would give the patient his best chance of relief of the symptoms or a cure." (PX5, p.6).

Dr. Young noted that he performed left carpal tunnel surgery on 6/29/15 and right carpal tunnel surgery on 8/12/15. (PX5, pp.6-7,10). He indicated that typically he allows the patient to continue working full duties until the surgery, and that "[f]ollowing the carpal tunnel surgery we typically take the patient off for a very short period of time, two or three days, and then place them on a work restriction." (PX5, p.8). He stated that per his 7/14/15 office note "[w]e gave [Petitioner] a lifting limit of no greater than five pounds." (PX5, p.9). He testified that these work restrictions would have been "... from the time of surgery until about six weeks postoperatively." (PX5, p.9). He also agreed that following the second surgery Petitioner would have taken off work for a few days and then placed on restrictions similar to those imposed subsequent to the first surgery. (PX5, p.10). Dr. Young noted that at the time of the surgeries Petitioner's right and left transverse carpal ligaments were severely thickened "... which would typically be indicative of an advanced carpal tunnel syndrome." (PX5, p.7,10).

Dr. Young testified that on 9/28/15 Petitioner was "... very pleased with the surgery, he was doing much better. Numbness and tingling had resolved in the hands. At this time we felt he was doing very well. We allowed him to return to work without restrictions. The plan was to see him back in the clinic on an as needed basis." (PX5, p.11). He agreed that for all intents and purposes that was an MMI release. (PX5, pp.11-12).

Dr. Young was then given a hypothetical concerning Petitioner's job duties at General Dynamics over the past ten years. (PX5, pp.12-15). As part of this hypothetical, Dr. Young was asked to "... assume that part of Mr. Bloodworth's job duties are in something called the propellant load and fill station and at that station a couple of machines called a large vibrator and/or a vibrating hopper are used by Mr. Bloodworth. Further assume he experiences vibrations directly into his hands at that station from 45 minutes to 1.5 hours on average each day... [and] that another part of Mr. Bloodworth's job at General Dynamics is in the bonding station. Here, further assume Mr. Bloodworth's hands are in frequent to constant motion and a significant amount of this motion requires pressure such as when he is gluing, pressing buttons, and locking projectiles into a fixture. Further assume he does this on average two and a half hours per day. Doctor, further assume another part of his job duties are in the chamber gauge station. Assume this station also requires frequent to constant motion of the upper extremities or hands and much

of that time is carrying and setting a chamber gauge master, which I believe is a part which weighs 30 pounds, from one spot to another spot within a small area. Assume this is done two to two and a half hours per day on average." (PX5, pp.12-14). Based on this information, Dr. Young believed that the job duties performed by Petitioner as described would cause or contribute to the development of the bilateral carpal tunnel syndrome that he diagnosed and treated. (PX5, p.14). Dr. Young also noted that the charges for his services were both reasonable and necessary. (PX5, p.16).

On cross, Dr. Young indicated that he did not recall reviewing any outside medical records other than the nerve conduction study in conjunction with his treatment of Petitioner. (PX5, p.16). He also did not recall reviewing any medical records from Dr. Parks, Petitioner's family physician. (PX5, p.17). When asked whether Petitioner provided any detailed description of his work activities with Respondent on his intake form, Dr. Young responded: "He mentioned a couple of activities, yes." (PX5, p.17). He agreed that the intake form in question noted that the injury occurred at work as the result of "repetitive use", and that writing, fine motor usage and utilization of small tools makes it worse. (PX5, pp.17-18). However, he agreed that Petitioner did not mention he was primarily writing at work or that the tools were being used at work. (PX5, p.18). He also noted that Petitioner reported, on his intake form, that his recreational pursuits included shooting guns and bows. (PX5, p.18).

When asked whether he had any other information regarding Petitioner's work activities other than the hypothetical, Dr. Young replied: "[t]he patient had provided a description of the work situation, but at the time of the evaluation I do not recall additional information specifically." (PX5, p.19). He agreed that Petitioner told him more about his job at the time of his initial visit on 5/7/15, but that he did not have any independent recollection of that conversation or record it anywhere in his office note. (PX5, p.19).

Dr. Young agreed that at the time of his last visit on 9/28/15 there were no objective abnormalities with respect to Petitioner's hands or wrists following the carpal tunnel releases. (PX5, p.20). He also did not anticipate any further treatment for Petitioner's bilateral carpal tunnel condition. (PX5, p.20).

Dr. Young agreed that when he saw Petitioner on 5/7/15 he was morbidly obese, and that obesity is a risk factor for the development of carpal tunnel syndrome, particularly in a younger patient like Mr. Bloodworth. (PX5, p.20). He also indicated that it was "probably fair" to say that as a younger patient becomes more obese it's more likely than not that the carpal tunnel condition, if it exists, would continue to worsen. (PX5, pp.20-21). In addition, while he did not see a specific mention of it in his notes, he noted that he would have to assume that Petitioner's condition had worsened over the previous six to seven years, otherwise he probably wouldn't have sought treatment for same. (PX5, p.21). He also indicated that "[i]t would certainly be a contributing factor" to the worsening of the carpal tunnel condition if Dr. Parks' records suggest that over the course of those years Petitioner's body mass index continued to increase. (PX5, p.21).

Finally, when asked whether Petitioner's work would not be a contributing factor if in fact Petitioner's activities were not as repetitive as described by Petitioner's counsel, Dr. Young

responded: "[a]ssuming that there's no repetitive use or there's no substantial grip force involved then I would be less inclined to say that it is a contributing factor." (PX5, pp.21-22).

Board certified orthopedic hand surgeon Dr. Mitchell Rotman testified that he examined Petitioner on 10/6/16at the request of Respondent. (RX1, p.4). Dr. Rotman agreed that prior to that he performed a record and video review on 10/19/15. (RX1, pp.4-5). Dr. Rotman recorded that Petitioner was "... an LCA Adjuster for General Dynamics. He was still working full duty as an LCA adjuster. He had been at General Dynamics since 2004. He started out in mortar and then switched to the LCA job, and he was mortar for about six or seven years." (RX1, p.5). Dr. Rotman agreed that Petitioner brought a job description with him on 10/6/16. (RX1, pp.5-6). He also agreed that he had reviewed a job video back in October of 2015, although he noted that it showed just the LCA jobs and not the mortar job. (RX1, p.6). However, he later indicated that he had reviewed Petitioner's description of his work activities in the mortar position. (RX1, p.9). In addition, he noted that he had had a chance to tour the General Dynamics' facility a few months earlier, in the summer of 2016. (RX1, p.9). Nevertheless, he indicated that he did not have a chance to look at the mortar position due to the fact that it had been closed. (RX1, pp.9-10). He noted that he did get to see "a lot of things" like the adjuster position that Petitioner described to him, and that the things that he observed in person and on the video were consistent with what Petitioner told him about the adjuster job. (RX1, p.10).

Dr. Rotman testified that "[t]he activities that can aggravate a carpal tunnel condition at work involve repetitive, heavy grasping, no just repetition. Computer activities, light activities that are repetitive are now not felt to be an aggravating factor for carpal tunnel. So, it needs to be heavy, forceful gripping, with or without vibration, with or without awkwardness positioning." (RX1, p.7). Dr. Rotman opined that Petitioner's "... main factor for carpal tunnel is obesity." (RX1, p.8). Dr. Rotman noted that "... we talked about heavy gripping increasing pressures in the carpal tunnel, which causes symptoms. When you are obese, you have increased water from the obese content from fat, and that water also gets into the carpal tunnel, and that increases the pressure, also. It would be the same as heavy gripping." (RX1, p.8). Dr. Rotman agreed that the records show Petitioner first sought treatment for numbness and tingling in his hands in August of 2012, at which time he reported gradually worsening symptoms over the prior three years. (RX1, pp.8-9). He also noted that "[a]t that time he was 6'8" and 283 pounds. That, obviously, would be morbid obesity." (RX1, p.9).

Dr. Rotman testified that he was of the opinion that Petitioner's "... work activities have – are not an aggravating factor and had nothing to do with his carpal tunnel condition and the need for surgery with Dr. Young." (RX1, pp.10-11). Dr. Rotman noted that "[h]is work at General Dynamics both from his description and the video and my tour of the plant and all the activities that I saw done there, which is basically all lines that were open at the time, there's nothing there that requires prolonged heavy grasping... The work is mostly self paced. There's some repetition in the activities because they're in one area for a certain length of time and then they go to another and then to another area, but it's not a high-paced assembly line type of plant... These aren't small bullets. These are pretty large objects that they're making, and there's lots of safety precautions, and things don't move that fast there, and there are so many modifications to the jobs over the years that have made it very safe, and I did not see any repetitive, heavy grasping at all in any of the activities that I reviewed there not only on my tour, but also on any of those video clips that I reviewed... Those videos in my opinion are not for

instructional purposes. Those were videos of the same pace that I saw when I visited. They were clearly done at the pace that I was familiar with during my visit, and they did not appear to be instructional videos ... I did not see any repetitive, heavy, forceful gripping activities in any of the jobs there, nor did he describe any jobs that involved heavy, repetitive work or exposure to vibration of any significance." (RX1, pp.11-12). Dr. Rotman also noted that "... there might be vibration [with the tanks], but not the type that's associated with heavy gripping in carpal tunnel. And he describes lots of different activities that he did, which is true. There are lots of different components to all these jobs. That's why it doesn't involve one thing done over and over again. He's exactly right in his description. Lots of different things, none of them together involve any repetitive type of forces, and they're split up and lots of multiple facets to the job, which then decreases the amount of repetition doing one particular thing. So, no heavy grasping in any of the jobs that he described or any of the jobs that I viewed." (RX1, p.13).

Dr. Rotman also agreed that increasing obesity with worsening of carpal tunnel symptoms suggest a relationship between or further support obesity's relationship with carpal tunnel condition. (RX1, p.13).

Dr. Rotman testified that at the time of his visit on 10/6/16, Petitioner was "[d]oing fine. He had no more numbness or tingling, maybe occasional cramping pain in the palm where the incisions are. He was quite happy with the results of the carpal releases." (RX1, pp.13-14). Dr. Rotman indicated that he prepared an AMA rating in accordance with the 6th Edition Guidelines, and that he rated each hand at 1% of the upper extremity. (RX1, pp.14-15).

On cross, Dr. Rotman agreed that Petitioner had bilateral carpal tunnel syndrome and that it was reasonable and necessary to perform surgery to correct same. (RX1, pp.15-16). He also agreed that he broke down the job video into six separate scenes, and that he would take Petitioner's counsel's word for it that they added up to a total of approximately 11 minutes. (RX1, pp.16-17). In addition, he agreed Petitioner informed him that he rarely if ever performed the activities depicted in the last two scenes. (RX1, p.17). Dr. Rotman indicated that whether he considered these last two scenes or not "[i]t wouldn't have mattered. All the scenes to me demonstrated no risk factors at all for carpal tunnel." (RX1, pp.17-18). He agreed to take counsel's word for it, however, that the total amount of video time would be seven minutes and eight seconds if you deducted these last two scenes. (RX1, p.18).

Dr. Rotman also agreed that Petitioner provided a detailed written description of his job duties as an LCA Adjuster in the tank line, breaking it down into four separate stations – namely, bonding, propellant load, propellant fill and chamber gauge. (RX1, p.18). In addition, he agreed that Petitioner felt the DVD didn't accurately reflect the pace of the job as he performed it in real life. (RX1, pp.18-19). He likewise agreed that Petitioner told him that there were aspects of the job of LCA Adjustor that were not shown at all on the DVD – for example, it did not show him climbing a vibrating tower or using a nylon rod to make sure pails in the propellant fill station did not stick. (RX1, p.19). More importantly, he agreed that he did not see any mortars department activity either on the DVD or when he toured the plant. (RX1, p.19). In addition, he agreed that he did not see any tools or machinery that vibrated in the first four scenes of the video. (RX1, p.20).

Dr. Rotman agreed that the development or etiology of carpal tunnel syndrome is multifactorial, and that some of those factors would include female versus male, postmenopausal female, diabetes and obesity. (RX1, p.20). He also indicated that "[r]epetitive, heavy grasping type of trauma" is also a factor. (RX1, p.20). He agreed that his testimony was that no matter what else is going on with the repetitive job, if there is no heavy grasping, then that activity could not in any way be responsible for the development of carpal tunnel. (RX1, p.20). He likewise agreed with the statement that if a person experiences vibration eight hours a day, that would not be responsible for their carpal tunnel so long as there was no heavy grasping or heavy gripping. (RX1, p.21). He indicated that it would require "... hand intensive being forceful, heavy hand work." (RX1, p.21). When asked whether the wrist would need to be in awkward positions frequently, Dr. Rotman responded: "No. I hardly see any jobs anymore with wrists in hyperextension or hyperflexion." (RX1, p.21). When pressed as to whether it was one of the factors in repetitive trauma, he stated: "Not necessarily. It is a factor, but I in 20 years haven't seen a job that involved repetitive hyperflexion or repetitive hyperextension, but activities that [we] see are involving heavy, repetitive forces but not ... extraordinary wrist positions." (RX1, pp.21-22). He also agreed that it was fair to say that while awkward positioning might be a factor, it was a very small one. (RX1, p.22).

With respect to vibration, Dr. Rotman testified that heavy grasping and the vibration would go together, noting that "[y]ou can't separate the two. If you're just around something that's vibrating or your hand brushes up against some vibrating container and you're holding it for a few minutes, that's not the same as holding a chainsaw or holding a grinder that's vibrating. So, it's a different kind of vibration we're talking about... He would have to be doing heavy grasping associated with the tool that's vibrating. That's where vibration comes into as a factor." (RX1, pp.22-23). Thus, he agreed that the amount of vibration is irrelevant to the development of carpal tunnel if and only if there is no heavy grasping. (RX1, p.23). He also indicated that the vibration and heavy grasping would have to occur at the same time. (RX1, p.24). He noted that "[i]f he's just around vibrating things and he's touching them and he's not grasping them heavily, that would have no bearing on an aggravation for carpal tunnel." (RX1, p.25).

Dr. Rotman agreed that the AMA rating does not measure disability, noting that "[i]t's an impairment rating." (RX1, p.25).

On re-direct, Dr. Rotman agreed that when he saw Petitioner on 10/6/16 the latter described to him what he felt his exposure to vibration at General Dynamics entailed, and that he took this into account when he rendered his opinion as to causation. (RX1, p.26).

On re-cross, when asked whether he wrote down word for word Petitioner's description of the amount of vibration that he experienced on the job, Dr. Rotman responded: "I tried." (RX1, p.26).

In a letter to Petitioner's counsel dated 2/6/17, Dr. Young stated that "[d]uring my deposition [on 9/27/16], I noted that Mr. Bloodworth's work situation was contributory to his development of carpal tunnel syndrome. [Redacted portion]. As for the 100% requirement of heavy grasping with forceful gripping being necessary for the development or aggravation of carpal tunnel syndrome, I do not believe that is the case. I believe it would be difficult to

quantify what exactly is meant by forceful gripping. The presence of heavy grasping and/or forceful gripping certainly is a risk factor and is more likely to cause or aggravate a peripheral compression neuropathy than a situation where it is not present, all other things being equal; however, once again, I do not feel that it is absolutely necessary. I am unaware of any studies which show this. Additionally, vibration has been shown to be a causative or aggravating factor for carpal tunnel syndrome. I also do not feel that simultaneous forceful or heavy gripping is obligatory. Based upon the records provided, I have found no reason to reconsider or revise my testimony regarding Mr. Bloodworth." (PX3).

Conclusions of Law

Based on the above, and the record taken as a whole, the Commission reverses the Arbitrator and finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental repetitive-trauma type injuries arising out of and in the course of his employment with Respondent, and that the date of manifestation was 9/24/14, or the date Petitioner completed a General Dynamics "First Aid/Injury Report" alleging the work relatedness of his injury and following the EMG performed on 8/29/14 wherein it was conclusively shown that he suffered from bilateral carpal tunnel syndrome. This finding is based on the credible testimony of Petitioner as to the repetitive nature of his work activities, particularly with respect to his job in the mortars department, where he worked for more than 6 of the 10 years leading up to the date of accident.

The Commission also finds that Petitioner's current condition of ill-being with respect to his bilateral carpal tunnel syndrome is causally related to said accident, based on the opinion of Dr. Young. The Commission finds the opinion of Dr. Rotman to be less than persuasive given that neither his review of the video nor his on-site observation of Respondent's facility included the mortars job that Petitioner worked for more than six years. The Commission also found unconvincing Dr. Rotman's rather inflexible position that no activity, no matter how repetitive, could cause or aggravate Petitioner's carpal tunnel syndrome without the presence of forceful grasping/gripping. Even if one were to accept this premise as true, the Commission notes that the Petitioner testified, without refutation, to certain aspects of his work activities that did in fact involve forceful grasping, in addition to repetitive use of his hands – including the forceful gripping associated with sliding paper cases off a rail into a hopper, the flipping of boxes back and forth when engaged in vacuum sealing and while performing chamber gauge work. (T.29,38,46). Likewise, Petitioner credibly testified that in the mortars job alone – where he worked shifts averaging 10 to 12 hours from 2005 to late 2011 -- he would make anywhere from 5,600 to 7,200 81-millimeter rounds a day and approximately 5,600 of the 120-millimeter rounds, and that this job involved the feeding of cases of nitrocellulose infused paper into a machine, constantly touching the vibratory bowl used in the process and frequent clearing of jams 20 to 30 times a day. None of Petitioner's testimony as to the activities involved in the mortars job was refuted by Respondent. The job video also did not even depict the work in question and no other witnesses were called to dispute Mr. Bloodworth's claims in this regard.

In addition, the Commission finds that proper notice was given to Respondent in the form of the "First Aid/Injury Report" partially filled out and signed by Petitioner on 9/24/14. The Commission also notes that Respondent stipulated to notice at the commencement of trial as evidenced by the Request for Hearing form admitted into evidence as Arbitrator's Exhibit 1.

Furthermore, in light of the above findings as to accident and causation, the Commission finds that Petitioner was temporarily totally disabled from 6/29/15, the date of his first surgery, through 9/28/15, the date he was released to full duty work and effectively found to be at MMI, for a period of 13-1/7 weeks.

The Commission also finds, in light of the above findings as to accident and causation, that Petitioner is entitled to reasonable and necessary medical expenses totaling $18,230.00 as set forth in PX4 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. These bills include Orthopaedic Institute of Southern Illinois in the amount of $5,651.00 (DOS: 5/7/15-9/28/15), Southern Illinois Orthopedic Center in the amount of $11,382.00 (DOS: 6/29/15-8/12/15), Brigham Anesthesia in the amount of $684.00 (DOS: 6/29/15) and Brigham Aneshesia in the amount of $513.00 (DOS: 8/12/15). (PX1). The Commission notes that treating orthopedic surgeon Dr. Young testified that the charges for his services were both reasonable and necessary. (PX5, p.16). Dr. Rotman, on the other hand, offered no opinion as to the reasonableness and necessity of said treatment, only that it was not causally related. (RX1).

Finally, as to nature and extent of the injury, and in consideration of the five factors set forth in §8.1b of the Act, the Commission finds the following:

With respect to factor (i), the reported level of impairment, the Commission notes that Dr. Rotman assigned an AMA rating of 1% of the upper extremity to each hand. The Commission assigns this factor moderate weight.

With respect to factor (ii), the occupation of the injured employee, the Commission notes that Petitioner was and continues to work as an "LCA adjustor" for Respondent. Given the repetitive activity associated with this job, and the nature of Petitioner's injury, the Commission assigns this factor moderate weight as well.

With respect to factor (iii), the age of the employee at the time of the injury, the Commission notes that Petitioner was 34 years old at the time of the accident. Given Petitioner's relatively young age, and the need to deal with the effects of the injury over the course of his remaining lifetime, the Commission assigns this factor greater weight.

With respect to factor (iv), the employee's future earning capacity, the Commission notes that there is no evidence Petitioner has suffered or is at risk of suffering a reduction in his earning capacity, particularly in light of the fact that he has returned to work in his previous occupation without restriction. Thus, the Commission assigns lesser weight to this factor.

Finally, with respect to factor (v), evidence of disability corroborated by the treating medical records, the Commission notes that Petitioner was diagnosed with moderate bilateral median neuropathy at the wrist (carpal tunnel syndrome) affecting sensory and motor components with no evidence of ulnar neuropathy at the elbow or cervical radiculopathy, per the EMG performed on 8/29/14. He subsequently underwent carpal tunnel releases on his left and right wrists on 6/29/15 and 8/12/15, respectively. He underwent occupational therapy thereafter and was eventually released to full duty work and at MMI by Dr. Young on 9/28/15. Petitioner returned to work for Respondent following his release and currently works in the mortar department. (T.56). He testified that "[a]fter the surgery, my hands felt great. All the numbness and tingling, the pain was gone. And the last several months, I get a little bit of tingling again, my hands start to cramp. But as far as overall, my hands feel great compared to what they were two years ago." (T.20-21). He also noted that "I don't have the grip that I used to. It's just not there anymore. My wrists are weak. I can't support myself to do a push-up anymore." (T.21). The Commission assigns this factor moderate weight.

Based on the above, and the record taken as a whole, the Commission finds that Petitioner suffered the permanent partial loss of use of 10% of his left hand and 10% of his right hand pursuant to §8(e)9 of the Act.

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 6/26/17 is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $558.75 per week for a period of 13-1/7 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 in the amount of $18,230.00 as set forth in PX4, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $502.88 per week for 38 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the left hand and 10% of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

18IWCC0548

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
o:7/16/18
TJT/pmo
51

SEP 6 - 2018

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the Majority's opinion reversing the Arbitrator's decision. I find the Arbitrator's decision to be thorough and well reasoned. Particularly persuasive are the arbitrator's detailed findings regarding Petitioner's medical records and opinions. I would affirm and adopt this decision.

Kevin W. Lamborn

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LOUISE M. CLARK,

Petitioner,

vs. NO: 03 WC 57915

TRAVEL PLAZA CAFE,

Respondent.

18IWCC0549

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, 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.

Procedural History

A previous Section 19(b) hearing was held on November 9, 2006 before Arbitrator Mathis. In his decision, dated January 12, 2007, he found that Petitioner, a cook, sustained accidental injuries on March 1, 2003 when she "slipped in grease on the floor near the kitchen, landing on her left hip." *Arb. Decision-1/12/07 at 3, unnumbered.* The decision indicates that Petitioner's Dr. Freitag[1] opined that Petitioner was suffering from spinal stenosis secondary to subluxation (retrolisthesis) and instability at L2-3. On September 8, 2005, he had recommended a decompression fusion of L1 to L3 but in his deposition on September 19, 2005 testified that if Petitioner did not want surgery, he would recommend a back brace or try cortisone injections. The Arbitrator found Petitioner's "current condition of ill-being including the retrolisthesis in her low back at the L2/3 level, were causally related to the Petitioner's work related accident as an

[1] The Commission notes that the original Arbitration decision refers to Dr. Freitag as Dr. Frietag.

aggravation of a pre-existing condition." *Id. at 5.* Temporary Total Disability (TTD) was not at issue. Medical bills of $5,089.14 were awarded with Respondent receiving no credit for the charitable write-offs reflected in the bills. The Arbitrator wrote:

> As the Petitioner's medical treatment has been hampered by her lack of funds and several treatment recommendations of Dr. Frietag [sic] have not been pursued, the Arbitrator finds that the Petitioner is not yet at a point of maximum medical improvement pending receipt of that treatment. *Id. at 6.*

Respondent filed for Review of that decision and the Commission, on October 4, 2007, found that the unpaid medical bills were only $445.86 but otherwise affirmed and adopted the decision.

The current Section 19(b) hearing, which is the subject of this Review, was held before Arbitrator Lindsay on November 18, 2016. The Arbitrator found Petitioner failed to prove that her condition of ill-being after November 9, 2006 (the previous hearing) remained causally related to her work injury. TTD and medical expenses were denied but Petitioner was awarded 50 weeks of Permanent Partial Disability under Section 8(d)2 of the Act.

Causation

The Commission notes the logical disconnect between the first Section 19(b) decision and the current one. The first decision found Petitioner's condition was causally related to her work injury and stated, "As the Petitioner's medical treatment has been hampered by her lack of funds and several treatment recommendations of Dr. Frietag [sic] have not been pursued, the Arbitrator finds that the Petitioner is not yet at a point of maximum medical improvement pending receipt of that treatment." *Id.* That hearing took place on November 9, 2006, and the decision was affirmed by the Commission on October 4, 2007, although the amount of medical awarded was reduced due to charitable write-offs.

Despite Petitioner's condition having already been found to be causally related as of November 9, 2006, the current Arbitration decision found that Petitioner's condition was not causally related after that date, and states:

> Based upon the Commission's earlier Decision, Petitioner's pre-existing retrolisthesis at L2-3 was aggravated by her work accident. However, at the present time the question is whether Petitioner's subsequent and ongoing complaints and symptoms, need for medical treatment and claimed periods of TTD were a consequence of her work accident. On that issue, Petitioner had the burden of proof and the Arbitrator has concluded that she failed to meet that burden. In so concluding the Arbitrator relies upon significant gaps in treatment followed by new and different histories of onset dates and the lack of a persuasive opinion from either Dr. Gornet or Dr. Wilson. *Arb. Decision-1/19/17 at 24.*

We generally affirm the Arbitrator's analysis and findings about Petitioner's lack of credibility regarding her symptoms and pain complaints. However, we modify the decision to find that

Petitioner's low back condition remained causally related to her work injury until the Section 12 examination of Dr. Kevin Rutz on April 15, 2008.

Petitioner testified that right after her accident while working as a cook for Respondent in 2003, she quit that job but she was also working at the time as head of the cafeteria at the New Berlin School District. *T.24.* She testified that her job with the school district was supervisory, she did not do any lifting, and could sit and stand as needed. *T.25.* On cross-examination, Petitioner explained that her job with Respondent was part-time but her position with the school district was full-time as a supervisor/cook. *T.40.* Petitioner testified that she quit her job at Respondent about a month after the accident but continued working for the school district. *Id.* None of her doctors restricted her from working initially after her accident and she continued working her full-time job for the next five years. *T.41.*

On June 11, 2007, Petitioner treated at Capitol Community Health Center. This record indicates she was "feeling good" with no complaints. It does mention that her chronic back pain was "tolerable" and she was continued on Tramadol. *Rx6.*

On direct examination, Petitioner couldn't recall when she began working part-time at Sam's Club but, on cross-examination, she testified it was "somewhere around" 2007/2008. *T.41.* She worked there a "little less than a year" at least three weekends a month about four hours each day on Saturday and Sunday. *T.27, 42.* She was a greeter and also did promotions. *T.42.* Petitioner testified that she was able to sit on a stool or stand on mats on the concrete floor, so she did both. T.43. She continued working at Sam's Club until June 16, 2008. *T.27.* We find that, based on Petitioner's testimony, she began working for Sam's club around July 2007.

We find Petitioner was not only working her full-time job but also the part-time job at Sam's Club and there were no further visits for low back treatment until after the previous Commission decision was issued on October 4, 2007. Petitioner testified that she received that decision in October 2007 and returned to see Dr. Freitag who referred her to Dr. Jung for some injections. *T.15-16.* She testified, "my back was just hurting all the time, down my – all the way down...my left leg, my left hip. I couldn't do a whole lot which I still can't but –". *T.16.* Petitioner testified that the pain she was feeling was the pain she had been experiencing ever since her accident. *Id.*

The records show that Petitioner returned to Dr. Freitag on December 4, 2007. *Px3.* At this point, we correct an error in the decision of the Arbitrator who wrote, "Petitioner had a four year gap in treatment between visits with Dr. Freitag in September of 2003 and December 4, 2007." *Id.* This is incorrect. The prior decision states that Petitioner had returned to Dr. Freitag on September 8, 2005. *Arb. Dec.-1/12/07 at 3.* Therefore, there was not a four-year gap in treatment.

Dr. Freitag noted Petitioner was "feeling progressively worse" and had to "resort to using a cane, which she borrowed from her friend, in the right hand. She is having more pain on the left than on the right." On examination, he noted that Petitioner "cannot straighten up" and "any attempt of straightening seemed to increase her pain." However, she had a **negative straight-leg-raising (SLR) test**. He diagnosed "**instability L2 to 3** of lumbar spinal stenosis." He stated

that, prior to any "regular fusion and decompression," he would recommend an X-Stop procedure at L2-3. But he first wanted to try an epidural steroid injection (ESI) to see if that helped significantly. Dr. Freitag wrote a prescription for a left transforaminal lumbar ESI at L2-3. We note that despite Petitioner telling Dr. Freitag that she was "progressively worse," she continued working at both of her jobs.

On December 13, 2007, Petitioner saw Dr. Hyunchul Jung, who recorded a history of low back and leg pain since 2001 after she slipped and fell down on the floor at work. We note that this record states the accident happened in 2001 rather than 2003 but do not find this error to be significant since the previous Commission decision found causal connection. Regardless, Dr. Jung wrote Petitioner's recent x-rays showed L2-3 instability and degenerative disc disease. He recommended an MRI followed by an ESI.

The MRI was performed on December 21, 2007, and the impression was "diffuse degenerative changes foraminal compromise only at L3-L4 on the left." *Rx5.* At L2-3, there was mild degenerative change with no evidence of neural compromise. That same day, Petitioner called Dr. Freitag's office requesting a "handicap placard for car." *Px3.*

Inexplicably, despite Dr. Freitag's prescription for an ESI at L2-3 and Dr. Jung's notation of L2-3 instability, Dr. Jung performed ESIs at **L4-5** on January 2nd and January 15, 2008. There is no medical opinion in evidence as to why these injections were performed at a different level nor how they might be causally connected to Petitioner's work-related condition.

On the bottom of a June 11, 2007 Capitol Community Health Center record is a handwritten note, dated January 29, 2008, that indicates "epidural x2 not successful." *Rx6.* That same day, a note from Dr. Jung states Petitioner "showed a significant relief though [she] still has significant remnant pain." He wrote, "the pain is a lot more tolerable than before, even though [she] still has some pain." He noted that Petitioner developed some oral thrush after the injection and decided to reserve further injections or treatment. *Px4.*

Petitioner testified she continued working her full-time job at the school district until February 29, 2008. *T.26.* She was asked:

Q: And why did you leave the job at that time?
A: Well, my main reason was I left because my back hurt but I also could not stand the fact that the kids were treated badly. A lot of the kids went hungry and it just broke my heart. *T.26.*

On cross-examination, Petitioner testified she retired because she had 10-out-of-10 pain. *T.46.* However, she admitted that her February 14, 2008 letter to the school district (Rx7), notifying them of her retirement effective February 29, 2008, does not mention anything about having back pain and only discusses issues with nutrition and how some of the teachers disciplined the kids. *T.46-47.*

Petitioner testified that her current pain is "a good 10" out of 10. *T.29.* It sometimes varies but she is never below an 8/10. *Id.* On cross-examination, she reiterated that her pain

level is 10/10 most of the time and 8/10 at best. *T.39*. She testified:

Q: How long has that been going on?
A: Since the accident happened.
Q: Ever since the accident you have been at 10 out of 10 in pain all the time?
A: Yes. *Id.*

Later, she testified that, after her first set of injections, her pain went down to 8/10 for a year. *T.61*.

We note that, although Petitioner claimed that she retired because she was in 8-10/10 pain, there is no contemporaneous medical record taking her off work by her physicians. Again, without any medical explanation as to how this might be related to Petitioner's work injury, Dr. Jung performed another ESI at **L4-5** on March 5, 2008. *Px4*. On March 19, 2008, Petitioner underwent another lumbar MRI which showed grade I retrolisthesis of L2 on L3 and the following degenerative changes:

T12-L1: unremarkable
L1-2: anterior bridging osteophytes are identified
L2-3: minimal diffuse disc bulge with lateral recess narrowing on the right with no neuroforaminal stenosis identified
L3-4: mild diffuse disc bulge with no neuroforaminal stenosis
L4-5: mild diffuse disc bulge with no neuroforaminal stenosis
L5-S1: mild diffuse disc bulge with no neuroforaminal stenosis

Dr. Freitag wrote a "To Whom It May Concern" letter, dated March 21, 2008, stating:

> When seen back on December 12, 2004, I recommended that she have an X-STOP procedure at #2-3 level due to lumbar spinal stenosis.
>
> A second opinion has been recommended. However, she finds it painful to sit up long periods of time, including sitting in a car, and I would strongly recommend that you find somebody closer than in St. Louis. *Px3*.

Petitioner returned to Dr. Freitag on April 8, 2008. *Px3*. This record indicates Petitioner had three "cortisone" injections and, "At this time she indicates that the pain is much better. Her left leg is better at present. She denies any significant numbness or tingling." Petitioner again had a **negative straight-leg-raising test** but she did have "somewhat decreased sensations in the superior lateral aspect of her left foot." The assessment was low-back pain with instability of lumbar L2 and L3 with lumbar spine stenosis. Under "Plan", it states:

> At this time we did discussed [sic] the options with the patient. Right now she is currently unsatisfied with the current treatment. She does want to have any further treatment at this time. We did discuss with her regarding X-STOP. At this time we would like to continue with observation. She will call us if there are any new problems or reoccurrence.

18IWCC0549

The Commission notes that this April 8th record does not explain why the ESIs by Dr. Jung were performed at L4-5 and not L2-3 as had been prescribed. Nor does it explain how these injections at a different level made her L2-3 instability and lumbar stenosis pain "much better". We also note some possible typographical errors in this record. It states that Petitioner was currently "unsatisfied" with the current treatment. However, this is inconsistent with her pain being "much better." It also states she "**does want** to have any further treatment at this time" but later states that they discussed the X-Stop procedure but were going to "continue with observation." It seems more likely than not that this record, in light of Petitioner's pain being "much better," meant to state that Petitioner was actually "satisfied" with the current treatment and "did **not** want" any further treatment at that time. This is also supported by the statement that Petitioner "will call us if there are any new problems or reoccurrence." Regardless, we find this record indicating her pain was "much better" to be inconsistent with Petitioner's testimony that the injections only reduced her pain to 8/10. *T.48.* We also note that Petitioner was not given any work restrictions and she continued to work at Sam's Club during this time. *T.51.*

It isn't clear when the Section 12 examination with Respondent's physician, Dr. Kevin Rutz, was scheduled but it was to take place on April 15, 2008. Just four days before that, on April 11th, Dr. Freitag's records indicate Petitioner called and "need[s] a letter faxed to attorney that has some restrictions on it for lifting and riding and driving…by Monday." *Px3.* Petitioner denied asking them to send a fax to her attorney but testified that she "may have just called in and asked for a work restriction." *T.49-50.* Without seeing Petitioner, Dr. Freitag gave her a work restriction of no lifting greater than 20 pounds. *T.51, Px3.*

Respondent's Section 12 physician, Dr. Rutz, testified via deposition on December 16, 2011. *Rx3.* He is a board-certified orthopedic surgeon who examined Petitioner and reviewed medical records on April 15, 2008. *Id. at 5-9.* Dr. Rutz testified Petitioner's complaints were pain in the back with radiation down the back of her left leg to the bottom of her calf. *Id. at 14.* On examination, Petitioner walked with a "markedly antalgic gait" where she would hold onto things when she would try to walk. *Id. at 15.* Dr. Rutz testified that he uses that term ("markedly antalgic") for people who seem to be magnifying their symptoms and it is "absolutely" a sign of magnification or exaggeration. *Id.* Petitioner overreacted to palpation in the midline lumbar spine, sacroiliac area, left buttock and left greater trochanter. *Id. at 16-17.* Dr. Rutz testified that Petitioner had weakness down to the left toe, which could be secondary to an impingement of the L5 nerve root. *Id. at 18.* He testified that Petitioner's overreaction to light and deep palpation was a "Waddell sign," that stood out to him as a sign of symptom magnification. *Id. at 20.* He interpreted x-rays taken in his office as showing moderate degenerative changes at L2-3 with retrolisthesis, mild retrolisthesis at 3-4, and a mild L4-5 degenerative spondylolisthesis related to the degenerative aging process. *Id.* Dr. Rutz reviewed Petitioner's March 2008 MRI film and opined that it showed severe facet arthropathy at L2-3 and L3-4. *Id. at 21.* His diagnosis was lumbar spondylosis with radicular complaints and a work-related hip contusion which was resolved. *Id.*

Dr. Rutz opined that Petitioner's radicular symptoms were most likely coming from the L4-5 level. *Id. at 22.* He testified that the retrolisthesis ("when the bones fall backwards") at Petitioner's L2-3 and L3-4 level, "tend not to pinch the nerves, whereas when they fall forward,

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they are more likely to pinch the nerves, profoundly more so." *Id.* Dr. Rutz opined that the distribution of Petitioner's symptoms was more in the L5 and S1 distribution and her toe weakness was consistent with the L5 nerve root. *Id.* He testified that it is uncommon to do surgery for a retrolisthesis, whereas it is very common for a degenerative spondylolisthesis. *Id.*

Dr. Rutz testified that the degenerative changes on Petitioner's x-ray were very easy to see but those degenerative changes did not correlate with her radiculopathy. *Id. at 23.* He opined that Petitioner's symptoms were much more consistent with the L4-5 spondylolisthesis. *Id.* He testified based on his examination and looking at the studies, the source of her complaints was being generated below the L3-4 level. *Id.* Dr. Rutz stated that it is not uncommon to see a retrolisthesis but the majority of the time they are not symptomatic. In contrast, the forward slipping degenerative spondylolisthesis is profoundly more common to be symptomatic. *Id. at 24.* Dr. Rutz testified that, even assuming the Commission has already determined that Petitioner sustained an aggravation of her pre-existing L2-3 retrolisthesis, he did not believe her symptoms, at the time of his examination, were secondary to that condition. *Id. at 25.* He based that opinion on the location of her complaints of radiculopathy, her examination, and her imaging studies showing a degenerative spondylolisthesis at L4-5. *Id.* Dr. Rutz believed Petitioner's symptoms were due to progressive degenerative changes. *Id. at 26.* He opined that, even if a fusion was performed at L2-3, it would not solve Petitioner's problems because the symptoms she is experiencing are not from a nerve root irritation at L2-3. *Id.* Dr. Rutz stated that an aggravation of the retrolisthesis at L2-3 does not affect the other lumbar levels and is not causing the problems at L4-5. *Id. at 27.* He opined that the "X-Stop" procedure was not reasonable or necessary for Petitioner because she did not have nerve impingement at L2-3 or L3-4, and if Petitioner did undergo that procedure it would be unrelated to her March 2003 work injury. *Id. at 28-30.*

On cross-examination, Dr. Rutz stated that the only Waddell sign he listed was overreaction to light and deep palpation, where the person squirms and moans unrealistically. Id. at 32. However, although it is not an official Waddell sign, he also mentioned Petitioner's gait because:

> when certain behaviors patients have when you evaluate them that are grossly out of proportion, meaning that the only people that should hurt that bad are people that literally just broke their spine in half and, when you examine thousands of patients a year and the only people that act like that are people in exams like this or people with psychological disorders. *Id.*

He testified that he doesn't depend on Waddell signs to determine if someone is magnifying their symptoms. *Id. at 33.* He agreed there are some people who require walkers and similar items for stability but:

> It is very different when they are able to walk into your office but, when you ask them to walk on exam, they grab a table, they grab a wall. They are inconsistent with their ability just to walk into the office. *Id.*

Dr. Rutz testified that Petitioner was "much more dramatic than just using a cane." *Id.* He stated

Petitioner's behavior in his office was "grossly, out of proportion ridiculous" and "not physiologic." *Id. at 33-34.* Dr. Rutz admitted that a person who falls on her hip can aggravate a spondylolisthesis in their back. *Id. at 37.* He did not believe Petitioner's L4-5 spondylolisthesis had been there at the time of her injury because there had been no mention of it in the records until she came to see him and he got new x-rays in 2008, which showed she was starting to develop early changes of it. *Id. at 38-39.* He testified that Petitioner had the L2-3 retrolisthesis at the time of her accident. *Id. at 40.* He was not sure about the L3-4 retrolisthesis, but there was no evidence that Petitioner had spondylolisthesis at L4-5 at that time. *Id. at 40.* Dr. Rutz stated that "based on her behavior in the office," Petitioner was not able to work. *Id. at 41-42.*

On redirect examination, Dr. Rutz noted that Petitioner had returned to her job as a cook after her work accident until she retired. *Id. at 42.* He stated that nothing in the records indicate Petitioner was taken off work when she retired. *Id. at 43.*

Following this examination by Dr. Rutz, Petitioner returned to Capitol Community Health Center on April 30, 2008, for a refill of her medications. *Rx6.* This record indicates she used a cane for mobility and had chronic back pain, for which she was seeing a specialist in St. Louis.

On June 11, 2008, Petitioner called Dr. Freitag's office wanting to know if she can get a medical leave from her part time job. *Px3.* A note on June 13, 2008 indicates that Dr. Freitag discussed Petitioner's request with her, and without seeing her, gave her restrictions of being unable to work until further notice and "possibly permanent." *Id.*

Petitioner testified she stopped working at Sam's Club on June 16, 2008, because she "couldn't stand it anymore because my back hurt so bad." *T.27, 41-42.* On June 27, 2008, Dr. Freitag completed an FMLA form for Petitioner indicating that her incapacity began on June 13, 2008 and was "Until further notice/possibly permanent." Petitioner's condition was listed as "low back pain w/ instability of lumbar L2 and L3 with lumbar spine stenosis." *Px3.*

On August 27, 2008, Petitioner treated at Capitol Community Health Center with a history of having hit her right leg over one week prior. There is no mention of any back pain. She followed up with Capitol Community for her right foot on September 3rd. Again, there is no mention of any back pain. Similarly, there is no mention of back pain on September 10, 2008, when she visited Capitol Community for bilateral foot edema that was stated to be "much better." *Rx6.*

We correct another error in the Arbitrator's decision which states, "Petitioner underwent no medical treatment for her low back between the time she left her job at Sam's Club and her car accident of September 30, 2008." *Arb. Dec.-1/19/17 at 25.* This is inaccurate since the records reflect Petitioner returned to Dr. Freitag on September 11, 2008, which was prior to her motor vehicle accident. *Px3.* This office note reflects that Petitioner and Dr. Freitag discussed Dr. Rutz's opinion that Petitioner's "current condition had nothing to do with her fall at work" on March 1, 2003. *Px3.* On examination, Petitioner was in "moderate distress" and used a cane in her right hand. She could not get up from the chair without using it. The Commission finds it interesting that Petitioner's straight-leg-raising test was now positive. Dr. Freitag indicated that

it was positive more on the left than on the right with her pain shooting into the left leg. His assessment was "instability of L2-L3 with spinal stenosis probably causing the weakness of the left leg." Dr. Freitag recommended electrodiagnostic testing, a CT myelogram, and a referral to Dr. Gornet for a second opinion.

Based on all of the above, we find Petitioner's testimony not credible. She claims that she had 10/10 pain since the accident yet was able to work for five years at her full-time job with no restrictions. By around July 2007, her condition was "tolerable" enough that she chose to also get another part-time job at Sam's Club. After she received the Commission's decision in October 2007, she started using a cane, which she borrowed from a friend, and returned to Dr. Freitag complaining of "feeling progressively worse." Yet, she continued working two jobs. Petitioner's claim that she retired from the school district in February 2008 due to her back pain is not credible as her retirement letter mentions nothing about back pain. Although Petitioner claimed that the injections in early 2008 only reduced her pain to 8/10, this is not consistent with Dr. Freitag's April 8, 2008 note indicating her pain was "much better," she had a negative straight-leg-raising test, and she was to call them "if there are any new problems or reoccurrence." We find it significant that Petitioner had no work restrictions until four days prior to her scheduled Section 12 examination with Dr. Rutz when she called Dr. Freitag's office wanting a restriction letter faxed to her attorney "by Monday." Petitioner underwent the Section 12 examination on April 15, 2008. After Dr. Rutz opined that Petitioner's condition was not related to her work injury, Petitioner called Dr. Freitag on June 11, 2008 asking for a medical leave from her part-time job at Sam's Club. Dr. Freitag provided this off work note after only a phone conversation and without any examination. When Petitioner returned to Dr. Freitag on September 11, 2008, she now had a positive straight-leg-raising test, which was a new finding. Yet, Dr. Freitag assessed "instability of L2-L3 w/ spinal stenosis probably causing the weakness of the leg." The Commission finds no medical support for the ESIs performed by Dr. Jung at the L4-5 level being causally related to Petitioner's work-related aggravation of the pre-existing retrolisthesis at L2-3. To the contrary, we find Dr. Rutz's opinion persuasive that Petitioner's condition at the time of his examination was due to degenerative problems lower in the spine, most likely L4-5, that were unrelated to her work injury.

Although we have found Petitioner not credible, we will still address the causation opinions of Dr. Freitag, Dr. Gornet, and Dr. Wilson. Regarding Dr. Freitag, the Arbitrator wrote that his May 15, 2012 office note "contains no opinion stating that her condition at that time stemmed from her 2003 work accident." *Arb. Dec.-1/19/17 at 25.* We find that, although this record does not specifically state Petitioner's condition was related to the "2003" work accident, it does indicate a history of ten years of low back pain after a fall at her previous work in a restaurant. *Rx12.* We find that this is a reference to Petitioner's claimed accident on March 1, 2003, while working for Respondent.

The Arbitrator also wrote, "While Dr. Freitag was noted to have passed away by the time the case went to hearing in 2016 it appears no attempts were taken to obtain a causation opinion from him or to depose him between November of 2006 and 2015." *Arb. Dec.-1/19/17 at 25.* However, later in the decision, the Arbitrator wrote:

While Dr. Freitag noted in his December of 2015 office note that Petitioner's symptoms

> began "with a fall thirteen years earlier this upcoming March", the Arbitrator does not find this to be an opinion based upon a reasonable degree of medical certainty and, even if so, it lacked any explanation or proof that it was based upon a complete consideration and understanding of Petitioner's treatment over the years, differing onset dates, and gaps in treatment. *Id. at 26.*

The Commission finds that, although some of the comments in Dr. Freitag's notes could be considered causation opinions, they are unpersuasive. As mentioned above, they are completely devoid of any explanation regarding how Petitioner's treatment at L4-5 was in any way related to his diagnosis of L2-3 retrolisthesis. Furthermore, there is a gap in treatment with Dr. Freitag between September 11, 2008 and May 15, 2012. During that period, Petitioner sustained two intervening motor vehicle accidents. The first was on September 30, 2008, (*T.33, Rx5, Rx6, Rx11*) and the second was on July 18, 2010. *T.34, Px4, Rx6.* Since Dr. Freitag never testified in this case, it is unclear whether he was aware of these accidents or how they may affect his opinion. Finally, a July 31, 2015 phone note (*Px3*) from Dr. Freitag's office at 8:24 a.m. states:

> Pt was crying on the phone because her pain has increased. She has not been seen in 2 years. She was given appt with JM for first available of 8/17. She is asking if anyone can see her sooner?

The phone note indicates, at 9:44 am:

> Spoke with pt and she said that her pain flared up yesterday after she did a lot of housework because she cannot let her house go according to pt. She tried taking 800mg of Ibuprofen and it has not helped.

On August 5, 2015, Dr. Freitag's office note states:

> Her pain has been well controlled over the last several years. On Thursday of last week, **she was on a stepstool cleaning a fan and was doing a lot of reaching along with twisting. That night, she began to have some pain. On Friday, the following day, she was in extreme pain and was unable to walk. She reported bilateral low back pain radiating in the S1 distribution to the ankle on the left.** She reports being nauseated from the pain. She went to express care and received a Toradol shot along with a prescription for Norco. Both of those have helped her pain significantly but she remains in pain today. She also reports new onset of left lower extremity cramping at night. She reports that in the past with similar symptoms she experienced relief with aquatherapy and injections. *Px3 (Emphasis added).*

The Commission notes that Petitioner was questioned regarding this history, but the date referenced by Respondent's attorney was December 15, 2015; not August 5, 2015. She denied giving Dr. Freitag a history on December 15, 2015 that her pain was well controlled for the last several years, that she had been on a step stool cleaning, and was unable to walk the next day. Since the record of Dr. Freitag containing that history was actually on August 5, 2015, we cannot say that Petitioner's denial was untrue. However, Petitioner later testified:

Q: If, in fact, you were up on a step stool cleaning a fan that would be different from what you have testified here today about you can only like do vacuuming; that would show you doing more?
A: Yes, but **I never get on a step stool to clean**. I have a Swiffer duster. *T.63 (Emphasis added).*

We note that the history of Petitioner having been on a stepstool cleaning is in both Dr. Freitag's handwritten and typed notes. *Px3*. We find that Petitioner did give that history to Dr. Freitag on August 5, 2015.

Dr. Matthew Gornet testified via deposition on September 23, 2010. *Px7*. The Arbitrator's decision, which is attached, contains a summary of his testimony so we will not repeat all of that here. However, there are a few significant portions of his testimony that are not included in the Arbitrator's decision. First, Dr. Gornet testified that Petitioner's initial problem was retrolisthesis at L2-3. *Id. at 22*. He was asked:

Q: Now, when you have retrolisthesis, and initially it was more at the L2-L3; correct?
A: Uh-huh.
Q: All right. With time will that slippage affect the adjacent levels of the spine?
A: Not really. It's really an independent process. I wouldn't say that that will affect another level. *Id.*

Second, Dr. Gornet testified that his opinion that Petitioner's symptoms were causally related to her work accident "assumed" she was truthful with him. *Px7 at 33*. He didn't see "any other plausible explanation" because her symptoms dated chronologically to the time of the accident. *Id. at 41*. He again stated that this assumed that Petitioner was credible and factually correct. *Id. at 42*. Third, he testified:

Q: So your opinion here today that it's causally related is based simply on her history; is that a fair assessment? That I had the accident, I never did well afterwards. And even though I was able to continue working my full time job that doesn't play a role in it because she said or told you I have been worse.
A: Well, I think I have answered what my opinion is based on, but what I would state to you is, **obviously, her history is an important piece because if she told me that a car hit her, then I would, obviously, be listening to that because that's what she told me.** So her history is an important part of that, but I base that on all the other things I've already gone through in this deposition. *Id. at 44-45 (Emphasis added).*

The Commission finds it interesting that Dr. Gornet would use being hit by a car as an example of an important history. Dr. Gornet never testified that he was aware of Petitioner's two motor vehicle accidents. Petitioner's first visit with him was on December 1, 2008, which was about two months after her first motor vehicle accident, but there is no mention of this intervening event in his notes. Petitioner's last visit with him prior to his deposition was on September 16, 2010. This was about two months after her *second* motor vehicle accident, yet

there was, again, no mention of it to Dr. Gornet. At the time of his deposition, on September 23, 2010, Dr. Gornet was recommending continued treatment including a new MRI and CT scan. *Id. at 13.* We find it very significant that, after his deposition, Petitioner never returned to Dr. Gornet for treatment. Based on the preceding, we find Dr. Gornet's opinion unpersuasive since it is based on Petitioner's credibility, which we have already found to be lacking, and an incomplete medical history regarding the two intervening motor vehicle accidents.

Instead of continuing to treat with Dr. Gornet and obtaining a fully-informed causation opinion from him, Petitioner was examined by her own Section 12 physician, Dr. Michael Watson, who testified via deposition on October 19, 2016. *Px8.* We point out some of the most significant portions of his testimony on which we have focused. Dr. Watson is a board-certified orthopedic surgeon but he does not perform spine surgery. *Id. at 5.* He reviewed records and examined Petitioner on September 7, 2016, which we note was over thirteen years after her work injury. *Id. at 6.* He testified that his diagnosis was the same as Dr. Freitag's, that being lumbar radiculopathy secondary to instability and retrolisthesis at L2-3. *Id. at 15.* He also opined that "to a lesser degree," Petitioner also had degenerative arthritis at L1-2 and L3-4. *Id.* He believed there was a causal relationship between Petitioner's condition and her work-related accident. *Id.* He was aware of Petitioner's intervening motor vehicle accidents and reviewed records related to those but opined that those events caused only temporary aggravations of her condition. *Id. at 17-18.*

Dr. Watson testified that Petitioner's capacity for work was "minimal" because she was 72 years of age, required a cane for ambulation, and was unable to stand or walk for more than 15 minutes at a time "by her description." *Id. at 19.* He did not believe she could lift anything greater than five pounds. *Id.* Dr. Watson stated Petitioner made several attempts to return to work, even as a supervisor in a cafeteria and also at Sam's Club, but wasn't able to tolerate that. *Id.*

On cross-examination, Dr. Watson testified:

Q: All right. And at what point, because I think your opinion here is that she had an injury which served as an aggravation to her preexisting retrolisthesis at L2-L3. Is that correct?
A: Yes.
Q: That's the nature of her injury here. Correct?
A: Yes.
Q: We do not have any involvement or injury as it involves the adjacent level above or below. Correct?
A: As a radiologist would put it, there were no acute changes. *Id. at 29-30.*

He testified Petitioner gave him a history of constant low back pain since her accident. *Id. at 34.* He couldn't recall which physician gave her work restrictions or when that was done. *Id. at 40-41.* He didn't know if Petitioner's job as a cook with Respondent was full-time or part-time but he assumed it was full-time. *Id. at 41-42.* He did not know when Petitioner started her job with the school district or whether she was working there at the same time. *Id. at 42.* He testified:

Q: Let's assume that the evidence will show that she was employed full-time for the

school district at the time of this accident and let's also assume that she continued working that job all the way up until February 2008 when she retired. Were you aware of that?

A: No. I thought it came later. *Id. at 43.*

He was also asked:

Q: All right. Now, is your opinion here as to aggravation for this accident in terms of her current condition, is it based in part upon the fact of your understanding or your assumption that she was not able to work after this accident?

A: It's based more on her description of the problems she had before and the problems that she had after and the consistency and the severity of her symptoms. In other words, she went from functional to not very functional following the injury with constant chronic pain. So I know, I think I know why you're asking the question because if she wasn't ever held off of work and by using that in my opinions to say that this was an aggravation or acceleration, I think what really makes me say that it's an aggravation or acceleration of a preexisting condition is her subjective story to me as to what kind of pain she was in prior to the injury and what kind of pain she continued to be in consistently following the injury.
Not so much if she was able to work or not, although she did paint the picture to me that things continued to progress to the point where she wasn't able to do any of those jobs that I mentioned. *Id. at 45-46.*

Dr. Watson testified that Petitioner told him she was forced to quit her job at the school because she had chronic pain and was standing on concrete surfaces. *T.48.* However, when he was shown Petitioner's February 2008 handwritten retirement letter, he agreed that it states nothing about her retiring because of her physical condition. *Id.* He admitted:

Q: That's inconsistent with what she told you as to why she left the school. Isn't that true?

A: Yes.

Q: That inconsistency, does that alter your opinion in terms of why she left in terms of her functionability issue of an aggravation to her retrolisthesis?

A: Well, I think you have two different sides of the story now. I mean it doesn't completely wipe out what she told me. You know, depends on the motivation. I mean there could be motivation for telling me it was pain.
There could be motivation for her telling the supervisor that she was quitting when by the way, I haven't been very happy with you since I started here. So it confuses things more, yes. *T.49.*

Dr. Watson reiterated that his opinion is based on Petitioner's history as to the chronic pain she was in. *Id.*

On re-direct examination, Dr. Watson testified that even if Petitioner developed some new pathology, her work accident would still be a contributing factor in her current level of function. *Id. at 57.* However, he testified that retrolisthesis at one level can cause "troubles" at

the level above or below. *Id. at 58.* The Commission finds that this opinion is not persuasive since it is completely at odds with the opinions of Dr. Gornet and Dr. Rutz on this issue.

Based on the above, we find Dr. Watson's causation opinion unpersuasive because it is based on his belief that Petitioner "went from functional to not very functional following the injury with constant chronic pain" and her "subjective story to me as to what kind of pain she was in prior to the injury and what kind of pain she continued to be in consistently following the injury." *Id. at 45-46.* We have already found, above, that Petitioner's complaints were not credible as of the Section 12 examination with Dr. Rutz on April 15, 2008. We also do not find Petitioner credible regarding the reason she retired from the school district nor the reasonableness and necessity of her work restrictions thereafter. Therefore, since the basis of Dr. Watson's opinion is, in large part, based on Petitioner's credibility, we find it unpersuasive.

To the extent that Petitioner may have had, and may continue to have, complaints or symptoms related to her low back, we find that she has failed to prove that the aggravation of her pre-existing retrolisthesis at L2-3 is the source of them. We also find that she failed to prove that any condition of ill-being at any other lumbar levels are causally related to her work accident. We find the opinion of Dr. Rutz, Respondent's Section 12 physician, the most persuasive in this case.

Medical Expenses

We next address Petitioner's claimed medical expenses contained in Petitioner's Exhibit 9. Most of these were incurred after April 15, 2008 and are denied based on our finding regarding causal connection. There is also a bill from St. John's Hospital for services in 2003, which is before the previous arbitration hearing and which was adjudicated in the previous Commission decision. The remaining bills relate to the injection performed by Dr. Jung on January 15, 2008. We find Petitioner failed to prove how the injections performed by Dr. Jung at L4-5 were in any way related to her aggravation of pre-existing retrolisthesis at L2-3. Therefore, we find that none of the bills submitted by Petitioner are compensable.

Temporary Total Disability

Petitioner has claimed temporary total disability (TTD) benefits from the time she quit her job at Sam's Club on June 16, 2008 through the date of her examination with Dr. Watson on September 7, 2016. For the reasons discussed above regarding causation, we find Petitioner has failed to prove that her work restrictions are related to the aggravation of her L2-3 retrolisthesis and she failed to prove that any pathology at other lumbar levels is causally related to her work injury in 2003. Therefore, Petitioner's request for TTD is denied.

Permanent Partial Disability

Petitioner sustained an aggravation of pre-existing L2-3 retrolisthesis while working for Respondent on March 1, 2003. Since her accident occurred prior to September 1, 2011, the permanency factors in Section 8.1b of the Act do not apply. In the previous Commission decision, it was noted that Petitioner testified she quit her job with Respondent in April 2003

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because "it became too difficult for her" although she continued to work her other job at the school district. *Arb. Decision-1/12/07 at 5, unnumbered.* Dr. Freitag and Dr. Gornet recommended an X-Stop procedure but Petitioner testified that she decided not to pursue it. *T.17-19.* Although we find that Petitioner's behavior and the medical records contradict her claim of having 8 to 10 out of 10 pain since the accident, and we find that her symptoms, as of April 15, 2008, were no longer causally related to her work injury, we find Petitioner is entitled to 15% of the person-as-a-whole under Section 8(d)2 of the Act. Based on her previously adjudicated average weekly wage of $486.34, her weekly permanent partial disability rate is $291.80.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $291.80 per week for a period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss of use of Petitioner as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 6 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/1/18
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLARK, LOUISE M
Employee/Petitioner

Case# **03WC057915**

TRAVEL PLAZA CAFE
Employer/Respondent

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On 1/19/2017, 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:

0834 KANOSKI BRESNEY
CHARLES EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0507 RUSIN MACIOROWSKI & FRIEDMAN L
THEODORE POWERS
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Louise M. Clark
Employee/Petitioner

v.

Travel Plaza Cafe
Employer/Respondent

Case # 03 WC 57915

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield,** on **November 18, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 1, 2003**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,336.22**; the average weekly wage was **$486.34**.

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.

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

ORDER

Petitioner failed to prove that her current condition of ill-being after November 9, 2006 is causally connected to her March 1, 2003 accident. Petitioner's claim for temporary total disability benefits and medical expenses is denied.

Respondent shall pay Petitioner permanent and total disability benefits of **$291.89/week** for **50 weeks** because the injury sustained the **10% loss of a person as a whole** pursuant to Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued between March 1, 2003 and November 18, 2016 and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

January 15, 2017
Date

JAN 19 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds[1]:

Medical records from Capitol Community Health Center have been admitted into evidence. These records reflect Petitioner's treatment at the Center for various medical complaints approximately 44 times between January of 2000 and December of 2002, and the following visits reflect complaints of back pain or leg pain:

06/28/00	complaints of left leg pain from her hip to her toes and bronchitis
09/9/00	complaints of low back pain and other symptoms
10/15/00	lumbar x-rays showing L2/3 retrolisthesis and degenerative changes
10/16/00	complaints of bilateral leg and low back pain radiating into her hips
12/6/00	complaints regarding her foot and other medical problems
06/4/02	complaints of low back pain
12/5/02	complaints of low back pain

Often times the foregoing low back complaints were followed by a diagnosis of "UTI. (Pet Ex. 2 in PX 2)

An October 17, 2000 x-ray of Petitioner's lumbar spine taken at St. John's Hospital showed evidence of significant degenerative disc disease on the lateral view with an exaggerated lumbar lordotic curve and retrolisthesis of L2 on L3 of about 3mm. There was also an anterior osteophyte on the body of L2 and L3 and some narrowing of L4-5. (RX 10 from PX 2, p. 1 of Mishkin IME report)

On March 1, 2003, Petitioner was employed as a cook for Respondent and as a cafeteria worker/supervisor at the Loami Elementary School kitchen.[2] On that date while in the course of her duties for Respondent, Petitioner sustained an accident when she slipped in grease on the floor near the kitchen, landing on her left hip.

Petitioner was seen at Memorial Medical Center's emergency room that same day complaining solely of left hip pain. A pain drawing was completed. On examination, her back was normal in appearance; however, tenderness to palpation of the left posterior buttocks was noted. She was diagnosed with a hip contusion and given Darvocet and Ibuprofen. No back complaints were noted. (PX 2 – PX 1)

Petitioner continued working for Respondent and the school district. She sought no further treatment until June 3, 2003 when she presented to Capitol Community Health Center (CCHC) reporting she had fallen on her hip while at work on March 12, 2003. She explained that she had been seen at Memorial Medical Center where an x-ray was performed and read as showing nothing acute and that using Ibuprofen had helped a little. Petitioner reported she was still having pain and had recently climbed a ladder and "started hurting worse past week." Petitioner reported it had always been hard to sit on her "right side since she fell and bruised." Petitioner located her pain over the left sacro-iliac joint and described the pain as a "deep soreness with shooting pain when sits down back of mid-thigh." On

[1] The Arbitrator notes that Respondent's exhibits contain a great deal of highlighting, none of which was done by the Arbitrator.

[2] a/k/a New Berlin School District

examination Petitioner had no tenderness over the lumbosacral spine nor did she have any paraspinal muscle tenderness. She was, however, tender over the sacro-iliac joint. She was diagnosed with left hip pain and given Vicodin and Relafen. (PX 2-px 2)

Petitioner returned to Capitol Community Health Care on July 21, 2003, complaining of persistent left hip pain, and a feeling like her left leg was going to give way. (Pet. Ex. 2 in PX 2) She reported that the medications had helped a little. (Pet. Ex. 2 in PX 2) An x-ray of Petitioner's lumbar spine was obtained on July 22, 2003, which showed a degenerative Grade I subluxation of L2 on L3, and she was referred to Dr. Freitag at the SIU Medical School clinic for evaluation of spondylolisthesis. (Pet. Ex. 2 in PX 2, p. 97; PX 1 in PX 2, p. 19) Petitioner was again seen at CCHC on September 14, 2003. Back pain was noted and she was scheduled for an MRI. (PX 2 in PX 2, pp. 105-106)

Dr. Freitag saw Petitioner on September 18, 2003. (Pet. Ex. 3 in PX 2) Petitioner was complaining of severe low back pain, and provided a history of a fall while working for Respondent. (Pet. Ex. 3 in PX 2) X-rays taken on September 18, 2003 and compared to the previous ones from March of 2003 showed mild worsening of Petitioner's retrolisthesis of L2 on L3 while the retrolisthesis at L1/L2 appeared stable. (PX 1 in PX 2, p. 20) Based upon his examination and review of the previous x-rays, Dr. Freitag felt that Petitioner was suffering from back pain secondary to retrolisthesis, and he recommended that she obtain an MRI for further evaluation. (Pet. Ex. 3 in PX 2) The MRI was eventually arranged through Capitol Community Health Care at St. John's Hospital and showed a moderate L2/L3 retrolisthesis with a moderate diffuse disc bulge. (Pet. Ex. 3 in PX 2) Petitioner returned to Capitol Community Health Care on October 29, 2003, with continued complaints of pain in her low back and going down her left leg. (Pet. Ex. 2 in PX 2) The doctor noted that Petitioner was not interested in pursuing any surgery, and it was recommended that she see an orthopedist and a pain clinic. (Pet. Ex. 2 in PX 2)

Petitioner signed her Application for Adjustment of Claim herein on November 25, 2013 alleging back and left lower extremity injuries as a result of a slip and fall on March 1, 2013. (AX 2)

The records of CCHC do reflect periodic visits there with reports of back pain during 2004. (PX 2 to PX 2)

At the request of Respondent Petitioner was examined by Dr. Marvin Mishkin on February 22, 2005. During the exam lumbar spine x-rays were taken. (RX 10 to PX 2, p. 1 of Mishkin IME report) and a written report followed.

Dr. Freitag examined Petitioner on September 8, 2005, approximately two years after his initial meeting with her. (PX 2 – p. 167) At that time she told him that "the two years have not helped her." She felt her problem was becoming more painful and she had a difficult time walking, felt unsteady and had to hold on to objects like walls. She was not using a cane because she didn't like them. Petitioner also reported having a hard time standing. Mild activities of daily living were making things worse and she was noticing more tingling into the left leg than the right leg. On examination she had mild weakness of her hip flexors and "maybe the left side slightly more than the right side." She was tender in the lumbar area. She had unremarkable deep tendon reflexes. X-rays showed pretty obvious instability between lumbar two and three." He felt she had clinically spinal stenosis secondary to the subluxation and instability at L2-3. He discussed with her the indications for surgery, including fusing 2-3. (PX 2, pp. 167 – 169)

Dr. Freitag's deposition was taken on September 19, 2005. (Pet. Ex. 5 in PX 2[3]) Dr. Freitag testified that the instability that he observed in his 2005 examination was consistent with the retrolisthesis that he had diagnosed in 2003. Regarding causation, Dr. Freitag testified that the work-related accident "seemed to be the precipitating event that was causing the problem that she had." (Pet. Ex. 5, p. 11 in PX 2) Dr. Freitag testified that Petitioner's initial complaints following the injury which focused upon the left hip more than the low back, was consistent with the injury that he diagnosed, as the nerve that comes out at the L2/3 vertebral interspace would affect that area of the hip. (Pet. Ex. 5, p. 11 in PX 2) He also testified that her complaints of weakness in her hip flexors were consistent with retrolisthesis at that level. (Pet. Ex. 5, p. 12 in PX 2) Dr. Freitag noted that a retrolisthesis (as opposed to the more common spondylolisthesis where there is forward slippage) is uncommon absent trauma. (Pet. Ex. 5, p. 22 in PX 2) He testified that degenerative changes would result in spondylolisthesis rather than retrolisthesis. (Pet. Ex. 5, p. 23 in PX 2) Dr. Freitag testified that it is virtually impossible to develop a retrolisthesis absent trauma. (Pet. Ex. 5, p. 24-25 in PX 2) Dr. Freitag testified that if Petitioner did not wish to pursue a fusion surgery, he would recommend that she try a back brace or cortisone injections. (Pet. Ex. 5, pp. 13-14 in PX 2) He also testified that she could modify her activities to accommodate her weakness and pain, perhaps utilizing a wheelchair. (Pet. Ex. 5, p. 14 in PX 2) Dr. Freitag noted that Petitioner might benefit from exercise in water. (Pet. Ex. 5, p. 21 in PX 2) Dr. Freitag acknowledged on cross-examination that part of Petitioner's inability to follow up with him was due to Petitioner's status as an indigent person, and that setting appointments with him for such patients through Capitol Healthcare was often a lengthy process. (Pet. Ex. 5, p. 16 in PX 2)

Dr. Mishkin's Section 12 report was issued on February 8, 2006. In the report Dr. Mishkin noted his review of CCHC records pre-dating Petitioner's accident, an October 17, 2000 x-ray of Petitioner's low back, and Dr. Freitag's deposition taken on September 19, 2005. Dr. Mishkin noted that the x-rays taken in his office on February 22, 2005 showed that Petitioner continued to have a retrolisthesis of L2 on L3; however, the degree of backward slip remained about the same. He also noted some progressive degenerative disease at L1-L2 with significant narrowing of that space and sclerosis of the endplates and anterior osteophytes. Petitioner also had some decrease in the height of the intervertebral discs at L3-4 and L4-5. Summarily, the doctor noted that the more recent x-ray showed progression of Petitioner's degenerative disc disease at multiple levels with the retrolisthesis at L2-3 present and the degree of slippage about the same. (RX 10 to PX 2, p. 2 of Mishkin report)[4] He felt Petitioner's degenerative disc disease pre-dated her accident but that the incident on March 1, 2003 resulted in bruising and contusions of the left hip and elbow. He noted she had no back complaints at the time of the accident and that those complaints did not present themselves until three months after the accident. Therefore, he was of the opinion Petitioner's back pain complaints were unrelated to the work accident and resulted from her pre-existing degenerative disc disease and retrolisthesis. (RX 10 to PX 2, pp. 2-3 of Mishkin report)

A second deposition of Dr. Freitag was taken on July 10, 2006, and he also was presented with the records of Capitol Community Health Care Center pre-dating Petitioner's accident in 2003. Based upon those records, Dr. Freitag acknowledged that Petitioner's findings of retrolisthesis must have been pre-existing, but opined that these conditions became symptomatic and were aggravated by Petitioner's fall on March 1, 2003. (Pet. Ex. 6, p. 7 in PX 2) He also noted that in most of those records the diagnosis related to the complaints of low back pain was urinary tract infection. (Pet. Ex. 6, p. 7 in PX 2) He also stated that the worsening in the degree of the retrolisthesis seen between July 22, 2003 and September 18, 2003, suggested a recent aggravation of the condition. (Pet. Ex. 6, pp. 9-12 in PX 2) Dr. Freitag also

[3] The first seven pages are missing from the exhibit.
[4] Dr. Mishkin's report is also labeled as pp. 314-316 of PX 2

confirmed that evidence that Petitioner's back pain was intermittent and isolated prior to her fall, and thereafter were persistent and more severe, would confirm that the fall on March 1, 2003 was an aggravating factor in her condition. (Pet. Ex. 6, pp. 12-13 in PX 2)

Dr. Mishkin was deposed on September 26, 2006. (RX 10 to PX 2, pp. 317 – 379)[5] Dr. Mishkin testified at length regarding the history of the accident as related to him by Petitioner as well as her treatment to date. (PX 2, pp. 327 – 332) While Petitioner denied any history of injury or trauma to her back or her hip pre-dating the accident she had x-rays from August of 2002 and she later recalled at accident, while working for Respondent, when she slipped on some ice while carrying food and fell onto her right hip. That occurred on August 18, 2002. (PX 2, p. 332) According to Petitioner she was seen at Memorial Medical Center, diagnosed with a bruise, and was asymptomatic within four months. (PX 2, p. 333) He felt Petitioner's degenerative disc disease pre-dated her accident but, based upon Petitioner's consistent report of no pre-existing back pain, he could not determine at the time of his examination whether or not there was a causal relationship between that pain and her x-ray findings and the accident of March 1, 2003. He attributed part of the problem to the fact there were no x-rays of her lumbar spine prior to July 22, 2003. (PX 2, p. 343)

Dr. Mishkin felt Petitioner needed aggressive back treatment, including therapy, and that she might be a candidate for back surgery to stabilize her lower spine. He did not feel she needed any treatment for her hip. At the time he initially examined Petitioner, he was unable to determine if she was at maximum medical improvement for her back given his inability to determine causation. He noted she was working with some restrictions and limitations. (PX 2, p. 344) Dr. Mishkin further testified that after his initial examination of Petitioner he was provided with medical records from CCHC pre-dating Petitioner's accident. (PX 2, pp. 345-346) Dr. Mishkin was then able to address causation and did so in his February of 2006 report. (PX 2, pp. 347 – 350) Dr. Mishkin felt Petitioner had sustained a left hip contusion and elbow contusion as a result of her fall at work. (PX 2, p. 350) Dr. Mishkin disagreed with Dr. Freitag's opinon that Petitioner's retrolisthesis condition was aggravated by the fall as there was no basis upon which to assume that. First the x-rays pre and post-dating the accident showed no significant change. Additionally the natural history of degenerative arthritis is such that it progressively worsens over time. He also thought that if Petitioner had aggravated her low back she would have complained about it within 24 hours of the accident which the medical records don't corroborate. (PX 2, pp. 350 – 354)

On cross-examination Dr. Mishkin was asked about the possibility that Petitioner's initial hip complaints were stemming from a back injury and he testified that could not be assumed. (PX 2, pp. 354 – 347)

It does not appear that Petitioner underwent any treatment between September 8, 2005 (the date of her her last visit with Dr. Freitag) and her 19(b) hearing of November 9, 2006.

Summary of the 19(b) Hearing (11.9.06)

Petitioner's case proceeded to hearing on a 19(b) petition on November 9, 2006. At the time of the hearing, the disputed issues were causal connection, medical bills, wages, and prospective medical care. (PX 1)

Petitioner testified that after she slipped, her husband was called, and he came and took her to the emergency room at Memorial Medical Center. (PX 2, T. 11) Petitioner testified that she continued

[5] Some pages of the deposition transcript are blank.

working following the incident but continued to feel pain in her left hip and low back. (PX 2, T. 12) With regard to the history contained in the June 6, 2003 CCHC office note, Petitioner testified that she had tried to climb a ladder to wash some windows but after rising to the second step she was hurting so badly that she had to get back down. (PX 2, T. 13) She testified that she had been experiencing back pain since her accident until she climbed the ladder, and that the pain she felt then was the same pain, only worse. (PX 2, T. 13-14) Petitioner testified that this increase in pain was a "temporary thing", and that thereafter her pain level returned to a baseline. (PX 2, T. 32) Petitioner testified that she declined surgery with Dr. Freitag as she wished to pursue options other than surgery. (T. 15-16 in PX 2) Petitioner testified that Dr. Freitag had recommended shots or a brace, but that she was unable to follow through on those recommendations for lack of funds and lack of authorization through worker's compensation. (T. 16 in PX 2) Petitioner returned to Dr. Freitag on September 8, 2005, nearly two years after her initial visit. (Pet. Ex. 3 in PX 2) She related that she had been episodically miserable since her last visit, and that her pain, if anything, was worse. (Pet. Ex. 3 in PX 2) She reported difficulty walking, and a feeling of unsteadiness. (Pet. Ex. 3 in PX 2) She related that any kind of activity, even ordinary daily activities, would exacerbate her pain. (Pet. Ex. 3 in PX 2) She also complained of numbness and tingling in her left leg. (Pet. Ex. 3 in PX 2)

Petitioner acknowledged in her testimony that she had had some back pain in the past prior to this incident, but she described that pain as temporary and not occurring very often. (PX 2, T. 17) She testified that following her fall on March 1, 2003, she had persistent and more severe left hip and back pain that had not gone away up to the date of hearing. (PX 2, T. 18) Petitioner testified that she was unable to sit for more than 10 or 15 minutes or stand for more than 25 minutes before her pain would become so severe that she had to change positions. (PX 2, T. 18) She testified that she sometimes got only 3 hours of sleep per night. (PX 2, T. 18) Petitioner testified that since her fall at work she had had tingling and numbness in her leg and sometimes had difficulty walking on her left leg. (PX 2, T. 18-19) She no longer was able to play with her kids or go for walks as she used to do. (PX 2, T. 19) Petitioner testified at that time that she used to walk at the mall several times a day for exercise but she had not been able to do so since her accident. (PX 2, T. 19) Petitioner testified that she no longer rode a bicycle or played soccer and football with her kids. (PX 2, T. 19) Petitioner testified that she had quit her job with Respondent because it became too strenuous, but had continued to work her full-time job at Loami Elementary School to the time of that hearing. (PX 2, T. 20-21) She testified that she was in charge of the kitchen, meaning that she would tell everybody what to do and she helped them out with little things if needed. She planned the menu and ordered food and occasionally helped in food preparation. (PX 2, T. 21) Petitioner testified that she did not do much of the physical work and had two other people working for her. (PX 2, T. 33) Petitioner testified that she has continued to receive treatment at Capitol Community Health Center and had a follow-up appointment set for November 29, 2006 at the time of the hearing. (PX 2, T. 30)

Petitioner acknowledged on cross-examination that she had sustained a fall on her right hip in August 2002 while working for Respondent. (PX 2, T. 23) She acknowledged that she received three or four months of treatment after that fall for right hip pain and a knot on her head. (PX 2, T. 24) Petitioner denied having suffered any low back pain after that fall. (PX 2, T. 24-25, 31)

Treatment Subsequent to the 19(b) Hearing

After the 19(b) hearing in November of 2006, Petitioner presented to Capitol Community Health Center (CCHC) on January 3, 2007 regarding painful sinuses. At that time it was noted that she had lower back pain for which she was taking Tramadol, as needed. (RX 6)[6]

The Arbitrator filed his 19(b) Decision on January 12, 2007, finding in Petitioner's favor on the issue of causal connection specifically finding that Petitioner's condition of retrolisthesis in her low back at the L2/3 level was causally related to her work accident on the basis of an aggravation of a pre-existing condition. (PX 1; RX 2) Petitioner was awarded medical bills and Respondent was ordered to pay the reasonable cost of the further treatment recommendations of Dr. Freitag. Respondent sought review of the Arbitrator's Decision.

Petitioner returned to CCHC on January 24, 2007 regarding bad headaches. (RX 6)

Petitioner returned to CCHC on February 7, 2007 in follow-up from the earlier visit. The doctor noted Petitioner had lower back pain continuously worse with sitting and standing. She was taking Flexeril and Tramadol for it. (RX 6)

When seen at CCHC on March 14, 2007 Petitioner's lower back pain was again noted and Petitioner told the doctor she was seeing Dr. Freitag. (RX 6)

Petitioner returned to CCHC on June 11, 2007 for a check-up. She was noted to have chronic back pain with pain and sciatica but was feeling good and had no specific complaints. Her back condition was described as tolerable and she was to continue with the Tramadol. (RX6)

The Commission issued its Decision on October 4, 2007, modifying the Arbitrator's Decision as it related to medical expenses. All else was affirmed and adopted. (PX 1; RX 1)

Petitioner underwent no medical treatment between June 11, 2007 and December 4, 2007.

Petitioner returned to Dr. Freitag on December 4, 2007, having last seen the doctor on September 18, 2003, over four years earlier. Petitioner reported that she was feeling progressively worse. (PX 3, p. 68) Dr. Freitag noted that Petitioner was now using a cane in her right hand and was having more pain on the left side than the right. Petitioner was unable to straighten up during the examination and remained in a bent forward position. Any attempt to straighten up would reportedly increase her pain. X-rays suggested some instability at L2/3 with lumbar spinal stenosis. Petitioner noted that she felt better when sitting down and bending forward. Dr. Freitag felt Petitioner had lumbar instability at levels 2 to 3 and his notes reflect discussions with Petitioner regarding various options for treatment. Since conservative care was not providing any improvement, Dr. Freitag recommended surgery. He recommended a trial of an "X Stop" at the 2/3 level before any fusion surgery was considered, but indicated that he would try one transforaminal epidural steroid injection first. Dr. Freitag also prescribed an adjustable cane and further noted that Petitioner was working. (PX 3, p. 68)

Petitioner was examined by Dr. Jung on December 13, 2007, at Memorial Medical Center. (PX 4, pp. 201-202) He noted Petitioner's history of low back and leg pain since a slip and fall at work. Petitioner complained of shooting, burning, sharp and aching pain aggravated by sitting, standing or walking. Petitioner completed a pain drawing showing lower back and left lower extremity complaints. Petitioner

[6] There is no record of an 11/29/06 CCHC visit as Petitioner testified to at the 19(b) hearing.

noted that she had pain in her lower back and left hip and leg and that sometimes her leg would give out when she was walking. (PX 4, p. 198) He noted she was referred for epidural steroid injections, but Dr. Jung recommended that she first undergo a lumbar MRI. Petitioner reported that she was working. (PX 4, p. 197)

Petitioner contacted Dr. Freitag's office on December 21, 2007 requesting a handicap placard for her car. The completed form was mailed out to Petitioner that day. (PX 3, p. 67)

Petitioner's lumbar spine MRI was performed at Memorial Medical Center on December 21, 2007, and showed degenerative changes at all levels of Petitioner's lumbar spine, but more pronounced at the L3/4 level where there was a left lateral disc bulge causing some compromise of the left neural foramen. (PX 4, p. 191; RX 5) Degenerative changes at other levels were described as mild.

Under the care of Dr. Jung, Petitioner thereafter underwent epidural steroid injections under fluoroscopic guidance on January 2, 2008 and January 15, 2008 on the left side at the L4/5 level. The diagnoses were listed as lumbar degenerative disc disease, lumbar disc bulging, and lumbar spinal stenosis. (PX 3, pp. 63-66; PX 4, pp. 169-170, 180-181)

Petitioner returned to see Dr. Jung on January 29, 2008, reporting significant relief from these injections though she still had significant remaining pain. (PX 4, pp. 159-160) Petitioner reported some oral thrush and soreness of her tongue after the second injection, and Dr. Jung advised her to seek care from her primary care doctor before proceeding further.

On February 29, 2008 Petitioner voluntarily resigned her position with the New Berlin School District (Loami Elementary School).

Petitioner returned to Dr. Jung on March 5, 2008, and received a third fluoroscopically guided epidural steroid injection at the L4/5 level. (PX 4, pp. 149-150)

On March 19, 2008 Memorial's Pain Management Program issued a script for a lumbar spine MRI "stat" to rule out an epidural hematoma or abcess. (PX 4, p. 138) Petitioner underwent another lumbar MRI on March 19, 2008, at Memorial Medical Center that showed a diffuse disc bulge at the L2 – S1 levels, with lateral recess narrowing on the right at L2/3. (PX 4, pp 138 -144; RX 5)

In a note dated March 21, 2008 and addressed to "To Whom It May Concern" Dr. Freitag noted that when he had seen Petitioner on December 12, 2004 he had recommended that she undergo an "X-STOP" procedure at L2-3 due to lumbar spinal stenosis. He added that a second opinion had been recommended and based upon Petitioner's representation that it was painful to sit up for long periods of time, including when in a car, the doctor was "strongly recommending" that someone closer than in St. Louis be found." (PX 3, p. 62)

Petitioner returned to Dr. Freitag on April 8, 2008, reporting that her pain had improved with the three injections that she had undergone. (PX 3, p. 59) Petitioner also reported that her left leg pain was better and she denied any numbness or tingling. On examination Petitioner had some "somewhat" decreased strength in the superior lateral aspect of her left foot but she was negative for straight leg raises. Dr. Freitag's assessment was instability of the lumbar L2/3 with lumbar spine stenosis. He discussed options with her and she expressed dissatisfaction with her current treatment. She did not wish to pursue any

further treatment and decided to continue with observation. Petitioner was advised to call the doctor with any new problems or reoccurrences. (PX 3, p. 59)

Dr. Freitag's records show that on April 11, 2008, Petitioner called requesting that a letter be faxed to her attorney indicating that she had some restrictions for lifting, riding and driving. Dr. Freitag issued a slip limiting Petitioner to no lifting over 20 pounds. (PX 3, pp. 58, 61)

At the request of Respondent, Petitioner was examined on April 15, 2008, by Dr. Kevin Rutz. In his report Dr. Rutz briefly reviewed Petitioner's history of injury. He noted that she reported that her back pain had gotten worse over the years since her initial injury, and she reported back and leg pain since that time. She reported using a cane for the past 6 months, that epidural steroid injections she had received in January made her 50% better, and that she had been unable to walk without holding onto something for the past five years. Upon examination, Petitioner was able to forward flex only with her fingers touching mid-thigh and extension only to neutral. He noted increased kyphosis in the thoracolumbar spine and tenderness to palpation in the midline of the lumbar spine as well as in the left SI area, buttock and greater trochanter. She had 4/5 strength in the left EHL. He opined that she had positive Waddell signs for overreaction to light and deep palpation. He reviewed films and diagnosed her with lumbar spondylosis with radicular complaints and work related hip contusion resolved. Dr. Rutz opined that Petitioner's current problems were unrelated to her work accident and that her current findings were all degenerative in nature. He stated that her anterolisthesis and retrolisthesis were not "traumatic type problems". He further noted that with the degree of difficulty that she had at that time, there was no way that she could have worked in any capacity in the preceding five years. He disagreed with Drs. Freitag and Mishkin that Petitioner's problems were related to the L2/3 retrolisthesis and, instead, felt they were related to her lower lumbar spine. He stated that her radicular complaints were not consistent with a radiculopathy originating at L2/3. He noted, though, that this had been an accepted work injury, and stated that before any further treatment she should undergo a CT myelogram. (RX 3)

Petitioner was examined at CCHC on April 30, 2008. Petitioner was using a cane for instability. Left leg pain and edema was noted. She was diagnosed with chronic back pain for which she was going to a specialist in St. Louis. (RX 6)

Another note from Dr. Freitag's office dated June 11, 2008, records a telephone call from Petitioner reporting she was having back problems and was requesting a medical leave from her current part-time job. Petitioner wished to speak with the nurse before the letter was written. Dr. Freitag discussed the request with Petitioner and she was listed as being unable to work until further notice, possibly on a permanent basis, with restrictions against prolonged standing or sitting. (PX 3, pp. 56-57; RX 10) Petitioner stopped working at Sam's Club on June 16, 2008.

On June 26, 2008 Petitioner signed a Medical Release allowing her records from Dr. Freitag to be shared with Sam's Club so that her request for FMLA/Disability could be completed. (PX 3, p. 55) On June 27, 2008 Dr. Freitag completed a Medical Certification Form on Petitioner's behalf. He indicated that Petitioner was suffering from low back pain with instability of her lumbar spine at L2 and L3 along with lumbar spinal stenosis. He further stated that the condition began on June 13, 2008 and would continue until further notice, noting it was possibly permanent. (PX 3, pp. 53-54, 51-52)

Petitioner was seen at CCHC on August 27, 2008 regarding an injury to her right foot that had occurred two weeks earlier. Petitioner said she had hit her right foot on a cabinet and it was swollen and painful. An x-ray was taken and pain medication was prescribed. By September 3, 2008 the doctor noted

Petitioner's right foot was more swollen than her left foot. Petitioner was using a cane for ambulation. Petitioner's right foot pain was better but the doctor noted bilateral foot edema and shortness of breath for which he ordered testing. She was put on Lasix with improvement noted. (RX 6)

Petitioner was re-examined by Dr. Freitag on September 11, 2008 at which time Petitioner reported on her recent examination in St. Louis wherein she was advised that her current condition was unrelated to her fall in March of 2003 and she told the doctor that she disagreed with the examining doctor's opinion. Petitioner also told the doctor of a recent episode lasting 2 -3 days wherein she had marked difficulty moving her left leg. Petitioner advised the doctor she felt best when reclining in the right lateral decubitus fetal position. On examination Petitioner appeared in moderate distress. She was using her cane in her right hand and could not get up from the chair without using it. When standing she did so leaning forward significantly, probably in the neighborhood of 15-20 degrees and unable to straighten up beyond that point. She expressed that she felt better when sitting. Straight leg testing was positive, more on the left than the right with her pain reportedly shooting into her left leg. Dr. Freitag's assessment was instability at L2-3 with spinal stenosis probably causing left leg weakness. He recommended an EMG-NCV and noted that she might benefit from a lumbar myelogram CT. He added, "She would be referred to Dr. Matthew F. Goinet [sic], he is in Chesterfield, Missouri, for another opinion since the so-called independent medical examiner apparently found it contradictory to the facts." (PX 3, p. 44)

Petitioner presented the Memorial Medical Center's emergency room on September 30, 2008 complaining of back pain after a low speed car accident in which the vehicle she was riding in was rear-ended and "jerked forward." A past medical history of back problems was noted. She was given a shot of morphine, underwent cervical and lumbar CTs, and given other pain medications while there. She was discharged with acute cervical and lumbar strains and acute abdominal pain. Petitioner complained of neck pain, lower back and abdominal pain. She gave a history of chronic back pain. A lumbar spine CT showed degenerative changes but nothing acute. (PX 4, p. 116) Petitioner was discharged with strains and sprains and told to follow up with her primary care doctor in 1 -2 days, if necessary. (PX 4, pp. 98 – 137; RX 5)

Petitioner was seen at Capitol Community Health Center on October 2, 2008 in follow-up from her car accident. She complained of neck pain, chest pain and lower abdominal pain since the accident. She was prescribed Darvocet for the muscular-skeletal pain and abdominal pain, assured she would get better, and given a prescription for her nausea. (PX 6, pp. 5-6; RX 6)

Petitioner was seen at Capitol Community Health Center on October 8, 2008 in follow-up from her car accident. It was noted that Petitioner's back was better. She had some edema down her leg. (PX 6, pp. 3-4; RX 6) As of October 15, 2008 Petitioner's neck pain had resolved but she still had some abdominal pain. (RX 6)

Petitioner continued to be seen periodically at CCHC between October 15, 2008 and December 1, 2008. No specific back complaints were noted. Petitioner was noted to be taking Lasix for edema in her legs. (RX 6)

Petitioner was seen by Dr. Matthew Gornet on referral from Dr. Freitag on December 1, 2008. (PX5, pp. 7-8) As part of the exam, Petitioner completed a questionnaire and pain drawing, the latter of which showed left-sided lower back and leg pain to her left knee. (PX 5, p. 10) According to the questionnaire, Petitioner's injury was work-related, having occurred on "March 1, 2002." She gave "11-07" as her date of first treatment (a cortisone injection). Petitioner reported being currently disabled and having begun

receiving disability checks from Social Security on "December 10, 2008 [sic]." (PX 5, p. 9) When examined by Dr. Gornet Petitioner was complaining of low back pain to both buttocks, particularly down the left leg to her foot, with weakness and giving out of the left leg and numbness. He recorded her history of her work accident. She denied any back problems prior to her injury. Petitioner reported she continued to work after the accident but that her symptoms became worse. She told the doctor that she was working two jobs and eventually stopped working for Respondent in April of 2002 [sic] and stopped working altogether in February of 2008. He noted that she currently had constant pain, worse with prolonged sitting, standing, walking or bending, with numbness, weakness and giving out of the left leg. Dr. Gornet reviewed x-rays taken that day as well as the prior September 30, 2008, MRI scan, noting obvious retrolisthesis at L2/3, and noted the same findings on prior scans on 12/20/07 and 3/19/08. He wanted to see her prior 2008 MRI and obtain a CT myelogram, stating that her problem might be difficult to treat but that she might be a candidate for a spinous process distractor at L1/2, 2/3 or 3/4 . He opined that her symptoms appeared related to her work accident.

On January 6, 2009 Petitioner called Dr. Freitag's office about her handicap disability sticker for her car; however, she was advised that the doctor felt that should be addressed by her primary care physician. (PX 3, pp. 42 - 43)

Petitioner returned to see Dr. Gornet on January 19, 2009 after the doctor had had a chance to review some of Dr. Freitag's notes. Dr. Gornet wrote, "It appears her symptoms are all causally connected to her work related injury back in 2002 as she described." Dr. Gornet agreed with Dr. Freitag that she would require a spinous process distractor at L2-3; however, Dr. Gornet would add L3-4. He explained to her that it might not necessarily relieve all of her pain; however, she would probably get some improved function. In the interim, she remained temporarily totally disabled. Dr. Gornet expressed the belief that Petitioner's requirement for treatment, based upon the information he had reviewed, was casually connected to her original work-related injury. (PX 5, p. 6)

Petitioner underwent a CT of the lumbar spine post-myelogram on January 19, 2009 per Dr. Gornet. It revealed: Accentuated lumbosacral angle; Multiple posterior element abnormalities including L4-5 facet joint autofusion bilaterally, L2-3 andL3-4 interspinous articulation, probably more broad based and sclerotic appearing at the L3-4 articulation; Annular disc bulges at L1-2, L2-3, and L3-4 with superimposed left-sided broad based herniation at L3-4; Moderate left L3-4 and mild right L3-4 foraminal stenosis with moderate to severe bilateral L2-3 foraminal stenosis and mild bilateral L1-2 foraminal stenosis; and a 6.5 mm. Grade 1 retrolisthesis at L2-3. (RX 5)

Petitioner contacted CCHC on January 28, 2009 requesting a parking sticker for her chronic back pain. She was given a script for Tramadol and told to follow up with an orthopedist. (RX 6)

As of April 8, 2009 Petitioner reported to CCHC that she was doing much better with her legs. No back complaints were noted. She was wearing support stockings for her bilateral leg edema and taking medication. Her primary concern was sinus related issues. She was noted to be using a cane. A history of chronic back pain was noted. (RX 6) Petitioner was again seen at CCHC on April 29, 2009 and July 1, 2009. As of July22, 2009 Petitioner was reporting that she was not currently sexually active due to her back injury. (RX 6)

Petitioner underwent a gastrointestinal consultation on June 29, 2009 at SIU School of Medicine. (RX 6)

Petitioner was seen at CCHC on January 20, 2010 reporting no specific complaints, having last been seen in late July of 2009. A history of chronic low back pain was noted. (RX 6)

Petitioner did not return to CCHC until June 3, 2010 at which time Petitioner had no specific complaints, including those of pain. She wished to try water exercises and she had two lesions on her back, chronic in nature. (RX 6)

On July 18, 2010 Petitioner was seen at Memorial Express Care for complaints stemming from a motor vehicle accident occurring July 16, 2010. Petitioner was a passenger in the care which was "T-boned" by another vehicle driving approximately 70 mph. Petitioner did not believe that she hit her head but she started having a severe headache and shoulder pain, along with nausea, later that evening. "Existing injuries prior to trauma were none." (PX 4, p. 60) Petitioner denied any back pain. (PX 4, p. 73) A CT of the cervical spine was taken due to Petitioner's history of head, neck and low back pain following the car accident. Moderate multilevel degenerative changes were noted. (PX 4, p. 78) A lumbar spine CT showed no acute osseous abnormalities and stable mild retrolisthesis at L2-3 resulting in bilateral neural foraminal compromise. (PX 4, p. 82; RX 5)Petitioner was diagnosed with a headache and back pain and told to follow up with her primary care doctor within 1 to 2 days if needed. Prescriptions were given. (PX 4, pp. 55 – 97; RX 6)

Petitioner followed up at Capitol Community Health Center on July 23, 2010 regarding her motor vehicle accident and resulting headache and whiplash. (PX 6, pp. 1-2; RX 6)

Petitioner returned to see Dr. Gornet on September 16, 2010, having not seen him since January 19, 2009. Prior to the exam she completed a medical information sheet indicating that her condition was related to a fall when she slipped on grease. She reported being currently disabled but did not indicate when her disability began. A pain drawing showed lower left back pain and left leg pain. She described her pain as a "9." (PX 5, pp. 3-4) When examined by the doctor she was reporting ongoing low back, left buttock, left leg pain and fairly severe pain into her posterior thigh to the knee. He noted that his original feeling was that she had structural problems at L2-3 and L3-4; however, he had not seen her in almost two years and her studies were quite out of date. He explained to Petitioner that she needed a new evaluation to address whether surgery would be appropriate and she understood. No specific treatment recommendations or testing was undertaken. (PX 5, p. 2)

Petitioner presented to CCHC on September 22, 2010 regarding some complaints of back pain "but babysitting." She was taking non-steroidal anti-inflammatory medication occasionally. Her condition was described as generally stable. (RX 6)

The evidence deposition of Dr. Matthew Gornet was taken on September 23, 2010. (PX 7) Dr. Gornet testified that he is a board certified orthopedic surgeon devoted to spine surgery. He testified that he first examined Petitioner on December 1, 2008 at which time he took a history from her as set forth in his office notes (discussed above)[7]. He added that her history prior to the slip and fall with Respondent was negative for significant back problems although he added that she recalled a mild strain one year before the accident. He examined Petitioner at their first visit noting she had decreased left ankle dorsiflexion. According to Dr. Gornet, Petitioner's x-rays revealed diffuse osteopenia with significant arthroloysis at L2 and L3. She also had some retrolisthesis at L1-2 (mild) and facet hypertrophy at L4-5. When he reviewed her MRI of September 30, 2008 he felt it showed significant facet changes at L4-5 which appeared to be a

[7] The Arbitrator notes that Dr. Gornet repeatedly referred to Petitioner's accident as having occurred in 2002,

spontaneous fusion of the facet joints at that level. Dr. Gornet further explained that retrolisthesis means the lumbar spine has slipped backwards on top of the other one. He wished for Petitioner to undergo a CT myelogram to further evaluate her spine and they discussed a spinous process distracter at that level. It was his opinion that her symptoms at the time of that visit were causally connected to her 2002 accident. Dr. Gornet testified that a spinous process distracter is a new treatment modality within the United States aimed at distracting the spine which unloads the posterior angles of the disc and unloads the facet joints. (PX 7, pp. 1 – 11, 12)

Dr. Gornet further testified that he saw Petitioner again on January 19, "2003 [sic." (PX 7, p. 11) By that time he had reviewed notes from Dr. Freitag and noted that Dr. Freitag had also recommended a spinous process distracter at L2/3, though Dr. Gornet also recommended the procedure at the L3/4 level as well. (PX 7, pp. 11--12) Dr. Gornet further garnered from Dr. Freitag's notes that Dr. Freitag felt Petitioner's condition was causally related to her work accident. (PX 7)

Dr. Gornet testified that he next saw Petitioner on September 16, 2010. At that time he felt that the studies done previously were now out of date, but felt that her symptoms were consistent with his previous diagnosis and findings. (PX 7, p. 13) Dr. Gornet confirmed that Petitioner was temporarily and totally disabled throughout his period of treatment. (PX 7, pp. 12-14)

On cross-examination, Dr. Gornet clarified that he felt that Petitioner's retrolisthesis pre-existed the fall that Petitioner had at work, but felt that Petitioner's fall aggravated those structural changes as well as the facet changes and foraminal stenosis so that Petitioner became significantly symptomatic. (PX 7, pp. 15-16) Regarding the finding of retrolisthesis, Dr. Gornet testified that patients with this condition can be asymptomatic. (PX 7, p. 20) He testified that based upon Petitioner's earliest films in 2003, he felt that she had retrolisthesis at L2/3, with a little bit of retrolisthesis at L3/4 and L1/2. On more recent scans done in 2008, he felt that her retrolisthesis at L3/4 was a little worse but essentially the same at the other two levels. (PX 7, pp. 22-23) Dr. Gornet testified that Petitioner's symptoms were coming from nerve root irritation and the structural problems in her back, and that the pain diagrams that she had drawn for him showing back pain that ran down her leg were consistent with the problems she had at the L2/3 and L3/4 levels. (PX 7, pp. 25-26) Dr. Gornet testified that he did not consider Petitioner's weight to be a contributing factor to her degenerative back problems. (PX 7, pp. 26-27) He also stated that he did not believe that osteoporosis was contributing to her condition. (PX 7, pp. 27-28) Dr. Gornet repeated his opinion that Petitioner's current condition was related to her work accident based upon a history of a mechanism that is consistent with aggravating her back condition and followed by a significant change in her pattern of seeking medical care for her back. (PX 7, pp. 29-30) He testified that he also based his opinion on the fact that the symptoms she described, including low back, left buttock and left hip pain, correlated to her MRI findings. (PX 7, pp. 30-31) On further cross-examination, he testified that an X-ray finding of retrolisthesis at L2/3 in October 2000 would not affect his opinion on causation and would not be surprising. (PX 7, p. 34) Dr. Gornet testified that the spinous process distracter does not have any major significant complications associated with it. He testified that they are easy to implant, extremely safe and can be removed without any significant problems. (PX 7, p. 50) He testified that any problem that Petitioner had with loss of bone density would be more in the vertebral body rather than in the spinous process, so would not be an issue with this procedure. (PX 7, p. 51) Dr. Gornet further testified that she was no longer a candidate for the procedure as it would be very bad for her. He explained that when he saw her the week before his deposition she was still feeling like her symptoms were affecting her quality of life and they were still essentially the same. He did not think she would benefit from a fusion. He testified that he would require new studies to determine if this minimally invasive procedure

was still appropriate, but that he would not recommend any more invasive procedure such as a fusion or other such surgical procedure. (PX 7, pp. 51-53)

When Petitioner presented to CCHC for a three month follow-up on December 22, 2010 she reported using a cane but getting around well. (RX 6)

As of April 6, 2011 Petitioner's condition when seen at CCHC was described as "doing overall well." Her back was still a problem but she didn't want to "[unclear]" anything. Petitioner was noted to be taking care of her granddaughter. (RX 6)

Dr. Murphy (CCHC) re-examined Petitioner on July 6, 2011. According to his notes, Petitioner had chronic pain since September 19, 2009 which was well controlled and she expressed no complaints of pain. Some back pain was noted on exam. (RX 6) As of September 14, 2011 Dr. Murphy described Petitioner's back pain as stable, again noting it began on September 19, 2009. Petitioner's exam was negative for back pain, joint pain, joint swelling, muscle weakness or neck pain. (RX 6)

Petitioner presented to Dr. Murphy on November 19, 2011 for gout in her left ankle. She gave a history of a red, swollen painful left ankle for one week. (RX 6) As of December 14, 2011 Petitioner's back pain, while chronic in nature, was in fair control with good days and bad days. (RX 6)

Respondent offered the evidence deposition of Dr. Rutz taken on December 16, 2011, addressing his opinions resulting from his examination of Petitioner on April 15, 2008. (RX 4, p. 10) Dr. Rutz testified that he is an orthopedic surgeon who has been practicing since 2003. (RX 4, p. 5) Petitioner complained to him of low back pain since the date of her work-related accident with pain radiating down the back of her left leg. (RX 4, p. 13-14) She reported that at the time of the examination, she was walking with a cane. (RX 4, p. 14) Dr Rutz noted that she would grab onto things as she walked, opining that this act was a sign of symptom magnification. (RX 4, p.p. 15-16) He noted that she had pain to palpation in the midline of the lumbar spine as well as the SI area, left buttock and left greater trochanter, though he alleged that her reaction was exaggerated. (RX 4, p. 17) He testified that she had weakness in her left EHL and equal (though absent) ankle reflexes. He testified that the finding of weakness in the left EHL could be secondary to an impingement of the L5 nerve root, but that the absent ankle reflexes were a "normal variant". (RX 4, p. 18) Dr. Rutz noted that x-rays done on the date of his examination showed moderate degenerative changes at L2/3 with retrolisthesis and mild retrolisthesis also at L3/4. He noted that she also had mild L4/5 spondylolisthesis at L4/5. (RX 4, p. 20) Dr. Rutz's diagnosis on that date was lumbar spondylosis with radicular complaints and a work related hip contusion that was resolved. (RX 4, p. 21) He opined that her radicular symptoms were coming from the L4/5 level. (RX 4 p. 22) Dr. Rutz stated that he felt that a further evaluation through a myelogram was required before considering surgical treatment through a fusion at that level. (RX 4, p. 23-24) Dr. Rutz testified that he did not believe that her complaints were coming from the retrolisthesis at L2/3. (RX 4, p. 25) Dr. Rutz opined that Petitioner's current complaints were the result of degenerative changes and not her work injury. (RX 4, p. 26-27) Dr. Rutz disagreed that the X-stop procedure at the L2/3 level would be appropriate as he did not see any impingement at that level. (RX 4, p. 27-28) On cross-examination, Dr. Rutz acknowledged that he found only one of the five Waddell signs positive but indicated that he was unaware of any standard requiring more than one positive sign to have a positive test. (RX 4, pp. 32-33) Dr. Rutz acknowledged that persons with back conditions can have pain while walking though he thought her responses were exaggerated. (RX 4 p. 34-35) He acknowledged that pain is subjective and that he cannot tell how much pain a person is in. (RX 4, p. 35) Dr. Rutz acknowledged that a person who falls on their hip can cause an aggravation of a spondylolisthesis in their back. (RX 4, p. 37) He acknowledged that a

person with degenerative changes and slippage between vertebrae in their back can become painful as a result of a fall that can trigger those conditions to become symptomatic. (RX 4, p. 37) Dr. Rutz testified that at the time of his examination he did not believe that she would have been able to work. (RX 4, pp. 41-42) Dr. Rutz testified that he performs about two IME examinations per weeks and that these are usually ordered by the employers. (RX 4, p. 41) He testified that he charges $1200 for each examination and each deposition. (RX 4, p. 42)

Dr. Murphy (CCHC) described Petitioner's back pain on March 14, 2012 as chronic and stable. On exam she had some back pain. (RX 6)

On April 27, 2012 Petitioner was contacted by Dr. Freitag's office regarding payment arrangements for her May 15th appointment. (PX 3, p. 41)

On May 14, 2012 Petitioner completed a New Outpatient Visit Intake Form for her upcoming visit at SIU Healthcare with Dr. Freitag. Petitioner listed her chief complaint as "back pain – sever [sic] – from an injury 10 yrs. ago. Case is still pending." Petitioner indicated she was retired. Petitioner also completed an Oswestry Disability Questionnaire (PX 3, p. 40) In conjunction with her exam, Petitioner underwent a lumbar spine x-ray that revealed severe diffuse degenerative changes with evidence of mild retrolisthesis at L1 on L2 and moderate retrolisthesis of L2 on L3 and moderate retrolisthesis of L3 on L4 showing motion with flexion and extension.

When examined by Dr. Freitag on May 15, 2012 Petitioner reported having had up to 10 years of low back pain initially after a fall at her previous work in a restaurant. She had previously seen Dr. Freitag three years earlier for injections which had helped but did not completely resolve the pain. Petitioner reported taking Tramadol for pain relief. Petitioner also complained of left leg pain, more than right leg pain, in association with her low back pain and that it was most noticeable and bothersome when standing for long periods of time and sleeping. She appeared in no acute distress and her bilateral lower extremities were well perfused with sensation grossly intact and 5/5 strength to hip flexion, knee extension and flexion, EHL, and FHL. Patellar tendon reflexes were+2 and she had mild tenderness to palpation diffusely over the paraspinal musculatures in the back. Dr. Freitag interpreted her x-rays as showing worsening retrolisthesis and the L2 on L3 retrolisthesis seemed to correlate with the type of pain she was experiencing. He recommended another epidural injection since they had previously helped. Petitioner "wished" about aggressive treatment and they discussed a fusion at one or more levels. (PX 3, pp. 31-32; see also RX 12)

Petitioner thereafter saw Dr. Salvacion of the Memorial Medical Center Pain Clinic on June 7, 2012. (PX 4, p. 47-48; RX 13) In conjunction with the exam Petitioner completed a questionnaire. She described her level of pain as a "2/10." Additionally, she completed a pain drawing showing pain in her mid-lower back and down her left hip, and leg. For an onset date, Petitioner reported "last year started again." (PX 4, p. 35) When seen by the doctor, Dr. Salvacion noted Petitioner was being seen due to a "recurrence of pain in her back down her left leg." He noted it was similar to the pain for which she had previously undergone steroid injections with good relief. "In fact, she has not really had much pain since the last set of injections." (PX 4, p. 47; RX 13) He noted that she had previously been treated by Dr. Jung at the clinic for similar complaints. Petitioner described pain as if her back was being punched – a throbbing, aching sensation – that was worse with bending or lifting. Dr. Salvacione noted that Petitioner's lumbar motion was limited in flexion and extension secondary to pain. Straight leg raising was positive on the left. A trial of epidural steroid injections was discussed. (PX 4; RX 13)

Petitioner underwent epidural steroid injections on June 18, 2012 and July 9, 2012. At the time of the second injection, Petitioner reported some improvement after the first injection but experiencing a flare-up of her pain after a lot of lifting activity the week before her appointment. (PX 4, pp. 19-30, 13-15; RX 14)

Petitioner was seen at CCHC on June 20, 2012 regarding chronic conditions of obesity, hypertension, and GERD. Petitioner was happy and smiling. On exam, it was noted she was using a cane. She had no cervical or thoracic spine tenderness. Her examination regarding her hips, shoulders, and knees was benign. No edema was noted in her extremities. Her assessments included "back pain without radiation, recurrent." She was to follow up with the pain clinic. (RX 6)

Dr. Murphy referred Petitioner for physical therapy aimed at her back and her initial evaluation was held on August 13, 2012. Petitioner was noted to lack lumbar extension, flexibility, core strength and poor posture all of which had led to a decrease in her physical activity and deconditioning. Petitioner was noted to be unable to do exercises on land secondary to a flare-up of pain with any movement. Therefore, it was felt she would benefit from skilled therapy intervention of aquatic physical therapy. Her potential t meet goals was described as "good" but the chronicity of her symptoms and severity of her lack of range of motion and ease of pain onset with slight movements might be contributing barriers to her meeting of goals. Petitioner appeared motivated. She was to attend therapy two times a week for four weeks. (RX 6)

Petitioner was again seen at CCHC on September 20, 2012 regarding her weight, hypertension, and pernicious anemia. Chronic problems included back pain without radiation and chronic pain. Her musculoskeletal exam was negative for back pain, joint pain, joint swelling, muscle weakness or neck pain. Petitioner was happy and smiling. No treatment recommendations were noted. (RX 6)

Petitioner again returned to CCHC on December 19, 2012 regarding her weight, hypertension, GERD, and back pain without radiation. She was advised to use ice/heat on her back, as needed, and to use over-the-counter arthritis rubbing cream as needed, rest/elevate painful joints, and use anti-inflammatory medications as directed. No notations regarding back pain were made except to state her musculoskeletal exam was negative for neck pain. (RX 6)

Petitioner again presented to CCHC on March 20, 2013 for complaints related to esophagitis, a hiatal hernia, and her chronic hypertension. Her musculoskeletal exam was negative for back pain and neck pain. (RX 6)

On June 19, 2013 Petitioner presented to CCHC with Dr. Murphy noting Petitioner's back pain was under poor control and he added two new medications. The date of onset for the back pain was listed as June 20, 2012. Her physical exam that day was positive for back and joint pain. (RX 6)

Dr. Murphy examined Petitioner on September 18, 2013 at CCHC for conditions unrelated to her claim herein. (RX 6)

Petitioner returned to see Dr. Freitag on December 11, 2013, approximately 1 ½ years since her last visit. (PX 3, pp. 25-29) She described her level of back pain as a "9/10." He noted his previous diagnosis of retrolisthesis of L2/L3 and L3/L4 in May of 2012 with degenerative disc disease at those levels. He noted that epidural steroid injections provided some relief, but that her pain would recur after a few months. Petitioner reported good benefit from aqua therapy. Pain was aggravated by laying or sitting for long times. On exam Petitioner had normal range of motion of all joints and normal muscle strength and tone.

She had minimal to no pain with internal and external rotation of her hips. Her posture and gait were described as normal. Some tenderness to palpation was noted over the spinous processes, mostly sacral. Dr. Freitag's diagnosis was listed as chronic low back pain secondary to L2/L3 and L3/L4 retrolisthesis and degenerative disc disease. He recommended an additional epidural steroid injection on the left at L2/3 and continued aqua therapy for six months and weight carrying limit of five lbs. She was to return as needed.

It does not appear that Petitioner underwent any treatment for back complaints between December 11, 2013 and July 31, 2015 when she called Dr. Freitag's office.

Petitioner telephoned Dr. Freitag's office on July 31, 2015, crying, and reporting that her pain had increased and she hadn't seen the doctor in two years and was to see him on August 17th but hoped she could be seen sooner. When the nurse spoke with Petitioner thereafter, Petitioner reported that her pain had flared up the day before after she had performed a lot of housework. A round of 800 mg. of Ibuprofen had not helped. She was told to continue with the Ibuprofen, use ice or heat, and continue stretching or she could contact her primary care doctor for additional pain medications or go to Express Care/ER/Prompt Care. (PX 3, p. 24)

Petitioner underwent lumbar spine x-rays on August 5, 2015. They revealed severe osteopenia likely reflective of underlying metabolic bone disease. She also had evidence of mild multilevel degenerative disc disease and advanced facet arthritis. (PX 3, p. 23)

Petitioner returned to see Dr. Freitag on August 5, 2015, having last seen him on May 15, 2012. (PX 3, pp. 17-20) Dr. Freitag noted that Petitioner had a previous history of low back pain secondary to retrolisthesis and degenerative disc disease at L2-3 and L3-4. Petitioner reported that her pain had been well controlled over the last several years. However, on Thursday of the previous week she was on a stepstool cleaning a fan and was doing a lot of reaching and twisting and that evening she began to have some pain. On Friday she was in extreme pain and unable to walk. Petitioner reported bilateral low back pain radiating into the S1 distribution to the ankle on the left. Petitioner had gone to Express Care and been given a Torodol shot and prescription for Norco which helped significantly; however, she remained in pain. She also reported a "new onset of left lower extremity cramping at night." She reported that similar symptoms had been relieved in the past with aqua therapy and injections. Petitioner denied any recent falls or any lower extremity weakness, numbness, tingling, saddle anesthesia, or bowel/bladder problems. Dr. Freitag noted some decreased strength on the left side and positive straight leg raising on the left. . X-rays remain the same as previous x-rays. He concluded that she had a history of L2/3 and L3/4 retrolisthesis and degenerative disc disease with an exacerbation of symptoms for a few days. He recommended aqua therapy, and if that did not give relief, two or three lumbar epidural injections. He noted that if both of these steps were unsuccessful he would refer her to Dr. Ganapathy for a surgical consultation.

Petitioner reported to Memorial's Rehabilitation Services at Koke Mill on August 26, 2015 for outpatient therapy. Her chief complaint was back pain with left sciatica to her foot. Petitioner stated that the condition had been present for 13 years due to a fall at work. Petitioner was retired. Petitioner was to attend therapy 2-3 times a week for twelve weeks. (PX 3, pp. 11-12)

Petitioner was seen again by Dr. Freitag on December 2, 2015, reporting good relief of symptoms with aqua therapy. (PX 3, pp. 1-3) Petitioner's history of low back pain secondary to retrolisthesis and degenerative disc disease at L2-3 and L3-4 was noted along with an exacerbation of lower back pain for

which she had been previously seen. She reported some radiating symptoms down her left leg in an S1 distribution that she described as tolerable. She was able to ambulate with a cane. Dr. Freitag noted that Petitioner's symptoms began with a fall 13 years ago next March. Dr. Freitag recommended that Petitioner continue with aqua therapy.

Petitioner had no further visits as Dr. Freitag passed away some time after the December 2, 2015 visit. Petitioner has undergone no further treatment since December 2, 2015.

On September 7, 2016, Petitioner was examined by Dr. Michael Watson at the request of her attorney. A report followed on September 9, 2016 in which the doctor reported that he had reviewed records from Dr. Freitag, a previous Commission "summary", MMC ER records, x-rays and MRIs, operative reports from steroid injections in 2007 and 2-0-8, ER records from 7.18.10, records of Dr. Salvacion dated 6.7.12, and records from Capital Community Health Center.

Dr. Watson's deposition was taken on October 19, 2016. (PX 8) Dr. Watson testified that he reviewed a lengthy list of records as well as the prior decision of the Commission. (PX 8, pp. 7-10) Petitioner provided Dr. Watson with a history of her injury and her treatment by Dr. Freitag including epidural steroid injections. (PX 8, p. 11) Petitioner told Dr. Watson that she had had constant and consistent back pain since her injury. (PX 8, p. 12) Petitioner told him that she has a hard time getting around and needed a cane for ambulation and could not stand more than 15 minutes before she needed a rest and could walk about 20 yards. (PX 8, p. 12) Petitioner told Dr. Watson that she had her husband do the shopping and if she went alone she would use a motorized cart. (PX 8, p. 12) Petitioner advised him that she had worked as a cook for 17 years until her injury after which she quit due to chronic pain while standing on concrete surfaces. (PX 8, p. 13) She also reported that she had attempted to work at Sam's Club as a greeter and doing product demonstrations but eventually quit that job as well due to pain from standing. (PX 8, p. 13) She reported that she had worked in a school cafeteria in a more supervisory role that she had done for several years until she was forced to quit that job as well. (PX 8, p. 13) Dr. Watson testified that during his examination he noted that she was in obvious distress from pain moving about the examination room, using a cane for ambulation. (PX 8, p. 14) Petitioner was able to sit in a chair but had difficulty getting up. (PX 8, p. 14) Petitioner was very tender in the lumbosacral spine and could only flex to touch her knees. (PX 8, p. 14) She had pain with hyperextension of the lumbar spine and lateral bending, which also caused pain that radiated into the left leg. (PX 8, p. 14) On the left she was tender in the sciatic notch, what Dr. Watson testified was typical for lumbar radiculopathy or sciatica. (PX 8, p. 14) Petitioner was unable to lie down on the exam table due to her low back pain. (PX 8, p. 14) Petitioner had positive straight leg raising in a seated position. (PX 8, p. 14) Dr. Watson testified that after his examination, his diagnosis was the same as Dr. Freitag's, which was lumbar radiculopathy secondary to instability and retrolisthesis at L2/3 and to a lesser degree the L1/2 and L3/4 levels. (PX 8 p. 15) Dr. Watson testified that there was a causal relationship between this diagnosis and Petitioner's work related injury in 2003. (PX 8, p. 15) Dr. Watson explained that he had reviewed records of treatment at Capitol Community Health Care prior to Petitioner's work accident and, though there were occasional complaints of back pain, they appeared to be temporary and short-lived, and at times associated with diagnoses of urinary tract infections. (PX 8, p. 16)

Dr. Watson testified that Petitioner had some pre-existing degenerative changes in her back, but following Petitioner's work injury, her complaints became chronic and constant and more severe. (PX 8, p. 16) Dr. Watson opined that Petitioner had had an acceleration or aggravation of her spine condition as result of her work-related injury that had continued up to the date of his evaluation. (PX 8, p. 17) Dr. Watson testified that he had reviewed emergency room records of two motor vehicle accidents that

Petitioner had suffered on October 2, 2008 when Petitioner's vehicle was rear-ended while sitting at a red light, and July 16, 2010 when a motorcycle ran into the driver's side of Petitioner's vehicle traveling at an estimated 70 miles per hour while Petitioner was seated in the passenger's seat. (PX 8, pp. 17-18) Dr. Watson testified that he discussed these accidents with Petitioner and concluded that based upon her description as well as the medical records that he reviewed that the accidents caused only a temporary aggravation of her back condition. (PX 8, p. 18) Dr. Watson testified that Petitioner's capacity for work was "minimal". He noted that she was 72 years old, required a cane for ambulation, was unable to stand or walk for more than 15 minutes at a time and would not be able to lift more than 5 pounds. He noted that she had made attempts to work but was unable to tolerate even working as a greeter at Sam's Club or in a supervisory role in a cafeteria. He therefore concluded that Petitioner had significant hurdles to being gainfully employed. (PX 8, p. 19) Dr. Watson concluded that Petitioner's prognosis was poor and that she was at maximum medical improvement. (PX 8, p. 19) When asked on cross-examination if his opinion on causation was based on an understanding that she was unable to work after the accident, Dr. Watson testified that it was based more on the description of the pain that she had after the accident as compared to problems that she had before the accident and not so much whether she was working in some capacity. (PX 8, p. 45) After discussion of findings of spondylolisthesis by Respondent's doctor, Dr. Watson affirmed that it was still his opinion that Petitioner's work accident was a contributing factor in her current condition. (PX 8, p. 57) He also acknowledged that the aggravation that she suffered at the time of her work injury could accelerate degenerative changes at levels above and below. (PX 8, p. 58)

Petitioner's case proceeded to arbitration on November 18, 2016. Petitioner was the sole witness testifying at the hearing. The disputed issues were causal connection, medical bills, temporary total disability benefits, and the nature and extent of any injury. (AX 1)

Petitioner testified that she was injured on March 1, 2003 when she slipped on grease and fell on her back and left hip. Following a 19(b) hearing held on November 9, 2006 Petitioner, who had been treating with Dr. Freitag, returned to see the doctor at which time he referred her for injections as her back was constantly hurting and she was having pain down her left hip and leg. Petitioner testified that she had been experiencing that pain ever since her accident.

Petitioner further testified that after undergoing the injections she returned to see Dr. Freitag in March or April of 2008 at which time they discussed an "X-Stop" procedure. She was then examined by Dr. Rutz at the request of the insurance company. According to Petitioner that exam occurred in St. Louis, lasted about five minutes and the doctor didn't do much except take some x-rays and have her touch her toes. She described him as not being very nice. Petitioner further testified that Dr. Freitag then referred her to Dr. Gornet for a second opinion in December of 2008 and he discussed the "X-Stop" procedure also.

Petitioner testified that her treatment was then delayed by depositions and she was unable to return to see Dr. Gornet until September of 2010. She then returned to see Dr. Freitag in May of 2012. Throughout this period of time Petitioner felt she wasn't getting any better.

Petitioner testified that she did not undergo the "X-Stop" procedure as she decided not to pursue it. Thereafter, Dr. Freitag had her go through another series of back in injections in June and July of 2012 and they helped to allow her to function on some kind of level during the day. Petitioner testified that she couldn't do eight hours of work but she could run her vacuum cleaner, load her dishwasher and "stuff like that." Petitioner further testified that the first three injections lasted almost a year while the second round of three lasted only six months.

Petitioner testified that she returned to see Dr. Freitag in December of 2013 at which time he again ordered more injections. She didn't get too much relief from the first injection but the second one helped for three to four months. She then returned to see Dr. Freitag in August of 2015 and again in December of 2015. Thereafter, Dr. Freitag passed away. Petitioner testified that when she last saw Dr. Freitag he recommended and ordered some aquatherapy which she pursued at the YMCA located on Archer Elevator Road. Petitioner testified to getting a lot of benefit out of the aquatherapy.

Petitioner acknowledged being examined by Dr. Watson at the request of her attorney. Other than that, she sees her regular doctor routinely and he asks her about her back and prescribed Tramadol for her to take as necessary. She also uses over-the-counter Ibuprofen because she finds the Tramadol upsets her stomach.

Petitioner testified that right after the accident she quit her job with Respondent. She was still, however, working as a supervisor at a school cafeteria for the New Berlin School District. As such, Petitioner would run the kids' tickets through the computer, put them in the computer, supervise and make sure everything got ready (salads, for ex.), and help put food out. She did not do any lifting but would ask others to do so. Petitioner was allowed to sit and stand as needed. Petitioner stopped working for the school district on February 29, 2008 because her back hurt and she could not stand the fact that the kids were being treated badly as many of them went hungry.

Petitioner further testified that when she left the job at New Berlin, she was already working for Sam's as a door greeter or person handing out samples. She could not recall when she started that job but she only worked weekends about four hours per day. She stopped working at Sam's as of June 16, 2008 when she noticed she couldn't stand it anymore because her back hurt badly. Petitioner testified that the standing and sitting associated with the job bothered her back and she could only use a stool for support and it had no back to it.

Petitioner testified that she spoke with Dr. Freitag about leaving the job at Sam's and he gave her a slip to do so. She has not worked anywhere since her job at Sam's.

Petitioner testified that her back is bad and was particularly bad the day of the hearing. Petitioner described her pain as being right across her lower back and down her left hip and leg. On a scale of 1 – 10, it would be a "good 10." Petitioner further testified that the pain sometimes varies from an "8" to a "10." If she is on her feet for a long period of time or sits in something uncomfortable it gets really bad. Riding in a car very far was described as "horrible." Petitioner estimated she could stand approximately 30 – 45 minutes before she would need to sit down. She can walk about 2 ½ - 3 blocks before needing to stop. Petitioner had a cane, prescribed by Dr. Freitag, with her the day of the hearing and testified that she must use it all the time. Petitioner also testified that if she sits too long (20 – 30 minutes) she needs to go and lay down. Petitioner testified that the chairs at the hearing location are horrible and that she had to sit and walk while waiting for the hearing to begin.

Petitioner further testified that she runs her vacuum cleaner about once a month but simply cannot do it every day as she had before her accident. She can load her dishwasher but it takes her about twenty minutes and then she has to sit down. She heats up her supper in the microwave and her husband does the laundry. She is unable to work in her yard or garden anymore because it bothers her back too much.

Petitioner acknowledged a car accident on September 30, 2008. She was sitting at a stoplight and a gentleman rear-ended her vehicle. Petitioner was seen at Memorial Medical Center and also treated with Dr. Murphy, her doctor. He started her on stronger Tramadol at that time. Petitioner denied that her back

pain was any worse after that accident. Petitioner also acknowledged having another accident on July 18, 2010 when a motorcycle T-boned the mini-van she was riding in. She denied receiving any injuries in that accident although she got her back checked out at Memorial Express Care. She denied any increased back pain due to the accident.

Petitioner testified that Dr. Murphy prescribes Tramadol occasionally. She has gained a lot of weight since the accident but has undergone the water therapy and lost 35 lbs. Petitioner testified that her back and leg pain has never totally gone away since the accident.

Petitioner was asked about her gaps in treatment with the doctors and explained that every time she would go in to see them they would ask for money that she didn't have and she couldn't afford to pay for treatment.

On cross-examination Petitioner testified that she is 72 years of age and became eligible for Medicare when she turned 65. She testified that she couldn't use Medicare for her back treatment because they knew it was workman's compensation and they wouldn't do that. She also acknowledged that her level of pain is usually a "10 out of 10" and has been since the accident.

Petitioner also acknowledged that she has been unable to work since June 16, 2008 to the present. She agreed that at the time of her accident she worked part-time for Respondent and full-time for the New Berlin School District as both a supervisor and cook. After the accident she continued working for Respondent approximately one month but she continued with the school district and did so for approximately five years. She agreed that no doctor restricted her from working during that five year time span. She also agreed that it was some time in 2007 when she began working part-time at Sam's and that she remained there a little less than a year. Sam's provided mats for her to stand on and stools to sit on. She could sit or stand and did both. Petitioner reiterated that she stopped working for the school district due to her back and the way the kids were being treated.

Petitioner agreed that she told Dr. Watson that she quit working at the school district because she had chronic pain while standing on concrete surfaces. She acknowledged to Respondent's counsel that she had testified on direct that she could sit also but added that she couldn't stand to stand on the floor. She agreed that she didn't tell Dr. Watson about retiring because of the issue with the school children but added that the doctor didn't ask her. Petitioner acknowledged RX 7, her letter of resignation with the New Berlin School District and that it says nothing about her back.

Petitioner also acknowledged that in April of 2008 her back was "doing the same." That would have been about two months after she had retired. She thought her pain was about an "8/10" at that time. She agreed that she had decided by then not to proceed with the "X Stop" and that the doctor might have discussed observing things to see how she did. She acknowledged calling Dr. Freitag's office three days later requesting restrictions but denied that she wanted it sent to her attorney. She agreed that the doctor didn't examine her at that time but gave her a work restriction of no lifting greater than twenty pounds. She also agreed that in June of 2008 she requested that Dr. Freitag fill out a medical leave form which he didn't so without the benefit of a physical examination. She did not know if he put down any recommended course of treatment when he filled out the paperwork.

Petitioner understood that Dr. Freitag filled out the paperwork on June 18, 2008 but she could not recall if she was examined by him two days before at which point she reported her leg pain was better.

Petitioner acknowledged having back pain before the accident and that she had undergone treatment several times for it between 2000 and 2002. She also had an x-ray taken during that time. She also acknowledged an accident at work in 2002 when she slipped and fell and landed on her right hip.

Petitioner testified that her back has gotten worse in the thirteen years since her accident. She further testified that the doctors told her that her condition could progressively worsen on account of the accident. She testified that she has never been told exactly what her back condition was and had never heard of the word "retrolisthesis." She understood that her back pain would increase by just performing activities of daily living. Petitioner testified that she stopped many of her household activities and outside yard work within a year of her accident. However, she was able to go to work.

Petitioner testified that her back pain goes all the way down her left leg to her toes. Petitioner acknowledged some problems with swelling in her legs for which she takes Lasix. She denied that part of the reason she needs a cane is because of the swelling in her legs. She acknowledged one episode of gout in her left ankle several years ago. She acknowledged no treatment or problems with her left hip. She denied ever being told she had bursitis in her left hip. She acknowledged problems in her thoracic spine with a hump/rounding in the middle of her back; however, it hasn't gotten worse over the years. Petitioner denied being told she had osteopenia or bone loss in her spine or that she has been given any medication for it.

Petitioner testified that her pain has never been below an"8." Even with a year of relief after the first set of injections, the pain level was an "8."

Petitioner denied telling Dr. Freitag on December 15, 2015 that her pain had been well controlled for the last several years. She also denied telling Dr. Freitag at that same visit that she had been on a step stool cleaning a fan and reaching and twisting and that the next day she was unable to walk. She denied being engaged in any such activity and had no idea where the doctor got that history. She denied getting on a step stool to clean as she has a Swiffer duster.

Petitioner testified that after the first motor vehicle accident her back pain was no more than usual but she went to get her back checked out. While Dr. Murphy gave her Tramadol she had already been on it but he did give her more. Petitioner did not recall telling Dr. Murphy anything about her second car accident with the motorcycle. Petitioner went on to acknowledge that after the first accident in which her car was rear-ended she was strapped on a board in route to the hospital and repeatedly asked them to put her on her side because it was making her back hurt. So, she did agree to some increased pain in her back after that accident but it was because of the board, not the accident.

Petitioner did not recall telling Dr. Watson that she had an increase in her back pain after the accident with the motorcycle. She agreed the motorcycle was going at a fast rate of speed.

Petitioner was asked about some of the history provided to Dr. Watson as he indicated she had been forced to quit the job at Sam's because she had difficulty standing for long periods of time. When asked if she had to stand a lot at Sam's, she replied "when she chose to." Petitioner added that she didn't have to stand but often did because it would hurt too much to sit.

On redirect examination Petitioner testified that her back pain before the 2003 accident wasn't nearly what she experiences now. Petitioner further testified that she continued at the job for the school district after quitting working for Respondent because she could sit longer and didn't have to get up and do

anything if she didn't feel like it. At the café for Respondent, she was always on her feet and had to do lifting.

Petitioner also clarified that after the first car accident in which she was rear-ended she had no immediate increased back pain after the accident; rather, it was brought on by being on the board. Once she was unstrapped from the board and allowed to turn over on her side her back started feeling better and she no longer felt nauseous. She thought her back felt worse because of the board for about one month after the accident.

On further cross-examination Petitioner denied telling Dr. Watson that her back returned to baseline about one to two days after the first motor vehicle accident. Petitioner saw Dr. Gornet after the first motor vehicle accident but denied that she did so because of that accident.

The Arbitrator concludes:

Issue (F) Causal Connection.

Petitioner failed to prove that her current condition of ill-being is causally connected to her March 1, 2003 accident. Petitioner failed to prove that her condition of ill-being in her low spine subsequent to the November 9, 2006 19(b) hearing was causally connected to her work accident. Based upon the Commission's earlier Decision, Petitioner's pre-existing retrolisthesis at L2-3 was aggravated by her work accident. However, at the present time the question is whether Petitioner's subsequent and ongoing complaints and symptoms, need for medical treatment and claimed periods of TTD were a consequence of her work accident. On this issue, Petitioner had the burden of proof and the Arbitrator has concluded that she failed to meet that burden. In so concluding the Arbitrator relies upon significant gaps in treatment followed by new and different histories of onset dates and the lack of a persuasive opinion from either Dr. Gornet or Dr. Watson.

At the time of the 19(b) hearing Petitioner testified that she had an appointment with CCHC scheduled for November 29, 2016. No record of such a visit was included in the record. Petitioner had a four year gap in treatment between visits with Dr. Freitag in September of 2003 and December 4, 2007. As of June 11, 2007 she had informed her doctor at CCHC that she was feeling good and had no specific complaints. She described her back condition as tolerable and was told to use Tramadol, as needed.

Upon returning to Dr. Freitag in December of 2007 Petitioner was referred to Dr. Jung who ordered an MRI which showed findings at L3-4. Interestingly Dr. Jung proceeded to give Petitioner injections at L4/5. Petitioner reported significant relief from these injections. She continued working for the New Berlin School District into late February of 2008. Her formal notice of retirement said nothing about back problems. She worked part-time for Sam's Club until mid-June of 2008. When she sought disability through Sam's the onset date of her back complaints was listed as June of 2008, not March of 2003. Dr. Jung never provided a causation opinion regarding the findings at L3-4 or the necessity of the injections at L4-5. Petitioner's injury, as determined in the first 19(b) hearing was to the L2-3 level. There is a "disconnect" between Petitioner's treatment in early 2008 and Dr. Freitag's note of April 8, 2008. He notes improved pain with the injections but described her condition as lumbar instability at L2-3. It is unclear if he had seen the MRI or realized she had undergone injections at L4-5 and not L2-3. While Dr. Freitag imposed restrictions at Petitioner's request on April 11, 2008 the doctor never stated that these restrictions were due to her March 1, 2003 accident. The same may be said of the June 11, 2008 restrictions. Again, during this time period Petitioner was working part-time at Sam's Club. While Dr.

Freitag subsequently completed disability papers for Petitioner stating she had low back pain and instability at L2-3 he gave an onset date of June 13, 2008. He never opined that any of these were due to her work accident.

Petitioner underwent no medical treatment for her low back between the time she left her job at Sam's Club and her car accident of September 30, 2008. She then followed up on two occasions at CCHC for complaints stemming from the car accident. She made no reference to her work accident of 2003. Furthermore, Petitioner continued to be seen periodically at CCHC between October 15, 2008 and December 1, 2008 but none of these visits were for specific back complaints.

Dr. Gornet then examined Petitioner on December 1, 2008. Petitioner was noted to be on social security. She provided him with incorrect information about her employment history, date of accident, and made no mention of her two car accidents or any gaps in treatment. Dr. Gornet had the opportunity to review some of Petitioner's prior medical records but not all of them – only "some of Dr. Freitag's notes." His causation opinion, as noted in his January 19, 2009 office note, is found to be unpersuasive due to the lack of accurate information and medical history upon which it was based.

After Dr. Gornet's visit with Petitioner in January of 2009 Petitioner's back condition appears to stabilize as few, if any, complaints are noted in the records of CCHC from January 19, 2009 through June 3, 2010.

On July 16, 2010 Petitioner was involved in another motor vehicle accident with headaches and whiplash thereafter. She then returned to Dr. Gornet on September 16, 2010, almost two years since their first visit. Based upon that gap in treatment Dr. Gornet had no specific treatment recommendations. While he was deposed later on in September of 2010 and again testified to causation, his opinion is found to be unpersuasive given the limited knowledge he possessed of Petitioner's medical history pre-dating his involvement and during the 2009-2010 gap in treatment.

Petitioner's treatment since September 16, 2010 has been sporadic and vague. As of December 22, 2010 she was getting around well. As of April 6, 2011 she was described as doing well overall. On July 6, 2011 it was noticed that her chronic pain "since September 19, 2009" (not March 1, 2003) was "well controlled" with no active pain complaints being noted.

Petitioner then returned to see Dr. Freitag on May 15, 2012, over four years since their last visit in 2008. Dr. Freitag's office note contains no opinion stating that her condition at that time stemmed from her 2003 work accident.

Petitioner underwent no treatment for any back complaints in 2014. When she contacted Dr. Freitag's office in July of 2015 regarding the need for an appointment, she gave a history of a recent incident stemming from housework and made no reference to her work accident of 2003. This was then followed up by their office visit wherein she represented that her back pain had been well controlled for the past several years until she had the episode while doing housework.

While Dr. Freitag was noted to have passed away by the time the case went to hearing in 2016 it appears no attempts were taken to obtain a causation opinion from him or to depose him between November of 2006 and 2015.

Petitioner has relied upon the testimony of Dr. Watson to establish causation, permanency, and lost time. However, the Arbitrator does not find Dr. Watson's opinion persuasive as he failed to adequately explain

or address Petitioner's significant gaps in treatment and differing dates of onset for her back pain in recent years (9.19.09 and 6.13.08, PX 3, pp. 51 -54 and RX 6)

The Arbitrator also had some concerns about Petitioner's credibility regarding her pain complaints and symptoms, reasons for retiring from the school job, and explanation for the history given to Dr. Freitag on August 5, 2015. Petitioner's testimony of having a pain rating of 10/10 most of the time since the accident and an 8/10 level of pain at the lowest is inconsistent with the medical evidence. The medical records show that Petitioner's pain complaints over the last 10 years have been generally stable or under control. The evidence shows that Petitioner's complaints and symptoms improved with the epidural injections in 2008 and 2012. Further, despite Petitioner's testimony as to her level of pain, she basically only takes over-the-counter medication. She also rejected past recommendations for any type of surgery. It is also instructive that none of Petitioner's physicians restricted Petitioner from working for five years and she in fact did work as a cafeteria supervisor and cook on a full-time basis until she retired on February 29, 2008. It is further instructive that Petitioner secured a part-time job at Sam's Club while working full-time at the school district. Her ability to work full-time and part-time at two jobs seem inconsistent and contrary to her perceived level of pain.

Regarding her testimony as to her resignation from the school being due to her physical condition, the letter of resignation fails to corroborate her testimony as it states nothing as to her physical condition being a basis for it. Furthermore, during this time span the medical evidence shows Petitioner's back and leg symptoms had improved due to the injections in early 2008. Finally, the gaps in Petitioner's treatment over the years are inconsistent with Petitioner's testimony regarding her level of pain complaints. In looking at the gaps in treatment, the Arbitrator has considered any difficulty Petitioner may have had in getting treatment due to her financial situation; however, her condition had been deemed covered by workers' compensation given the Commission's earlier Decision. As such, she had rights under Section 19(b) available to her in order to seek treatment more efficiently. In the last seven years, however, she has never chosen to proceed in that fashion.

Petitioner returned to see Dr. Freitag on August 5, 2015 (and not December 15, 2015 as discussed during the hearing) and after a three year gap in visits. Petitioner stated that her pain had been well controlled over the last several years and she further described a specific date of onset for her presenting complaints (ie., the previous week while cleaning a fan). While, at trial, Petitioner denied stating that history to the doctor, she provided no reasonable explanation for why it was contained therein nor had she taken any steps to have it corrected. Despite her denial of the history, the history of her condition being well controlled over the last several years does seem corroborated by the overall medical records admitted into evidence. Petitioner underwent very little active treatment for back complaints between 2012 and 2015. Indeed, Petitioner sought no medical treatment for any back problems in 2014.

While Dr. Freitag noted in his December of 2015 office note that Petitioner's symptoms began "with a fall thirteen years earlier this upcoming March", the Arbitrator does not find this to be an opinion based upon a reasonable degree of medical certainty and, even if so, it lacked any explanation or proof that it was based upon a complete consideration and understanding of Petitioner's treatment over the years, differing onset dates, and gaps in treatment.

Issue (J) Medical Services/Bills.

Consistent with her causation determination, no medical bills are awarded.

Issue (K) Temporary Total Disability (TTD) Benefits.

Consistent with her causation determination, no TTD benefits are awarded. Petitioner failed to prove that any lost time she incurred after November 9, 2006 was causally related to her work accident of March 1, 2003.

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

Based upon the evidence, and consistent with her causation determination set forth herein, Petitioner sustained an aggravation to her pre-existing retrolisthesis at L2-L3 as a result of her work accident on March 1, 2003. Despite the work injury, Petitioner was not restricted from working and continued performing her full-time job duties at her school district job, as well as securing other part-time employment. At some point in time after leaving her part-time job at Sam's Club she began receiving social security benefits which could impact her ability to continue working. Based upon this evidence, Petitioner sustained a permanent partial disability loss of 10% loss man as a whole as a result of the work injury.

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DANIEL L. GALARZA, SR.,

Petitioner,

vs. NO: 09 WC 45691

CITY OF CHICAGO, DEPT. OF STREETS AND SANITATION,

18IWCC0550

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h) and §8(a) OF THE ACT

This matter comes before the Commission pursuant to Petitioner's Petition under Sections 19(h) and 8(a) of the Act. A hearing was held before Commissioner Michael J. Brennan on April 6, 2018. After reviewing the record in its entirety and being advised of the applicable law, the Commission hereby grants Petitioner's Petition and finds that by the parties' stipulation, Petitioner established a material increase in his condition as required under Section 19(h) of the Act. The Commission finds that Petitioner is entitled to an additional 25% loss of use of the left leg pursuant to Section 8(d)(2) of the Act. The Commission awards Petitioner temporary total disability (TTD) benefits from February 3, 2014 through September 7, 2014, and from March 11, 2016 through May 24, 2016. The Commission finds that Respondent is entitled to a credit in the amount of $28,163.40 pursuant to Section 8(j) of the Act.

Procedurally, this matter was first tried under Section 19(b) of the Act before Arbitrator Robert Lammie on October 21, 2010. The issues raised at arbitration were causal connection, medical expenses, prospective medical, and TTD. Petitioner was a union truck driver; his primary duty was driving vehicles for Respondent's Bureau of Forestry. The parties had stipulated that Petitioner, a 47-year-old man, had an accident on October 19, 2009; Petitioner was unloading a truck inside Respondent's garage when his left foot became caught in the cracked concrete of the

garage, he twisted his left knee, fell, and hit his left shoulder and ribs. The Arbitrator found that Petitioner's left shoulder and left knee conditions were causally related to the October 19, 2009 accident; he subsequently awarded reasonable and necessary medical expenses, and prospective treatment by way of further physical therapy; TTD no longer became an issue at the conclusion of the arbitration hearing. (PX12).

The parties next proceeded to final hearing on May 17, 2013 before Arbitrator Barbara Flores. The issues raised at arbitration were medical expenses and nature and extent. The Arbitrator noted that Petitioner had undergone left shoulder arthroscopic repair of the rotator cuff, subacromial decompression, and glenohumeral joint arthroscopy with extensive debridement; the surgery took place on February 24, 2010. Arbitrator Flores stated in her Decision that Dr. Heller had noted a full-thickness tear intraoperatively. Petitioner also underwent a left knee arthroscopy, partial medial and lateral meniscectomies, chondroplasty of the patellofemoral joint, medial femoral condyle with microfracture of lateral femoral condyle, and excision of osteophytes; this surgery took place on May 17, 2010. Thereafter, Petitioner continued to receive treatment for his left knee with Dr. Michael Maday through May 22, 2012. (Arbitrator Flores' 2013 Decision, pg. 1; PX12).

The Arbitrator stated that Petitioner proceeded with a functional capacity evaluation (FCE) after completing physical therapy and receiving additional cortisone injections. The March 1, 2011 FCE was deemed valid, and Petitioner was released to work at the medium physical demand level. This "was consistent with a truck driver/clam operator job description and Petitioner's indication that he was also required to lift up to 100 pounds at work." (Arbitrator Flores' 2013 Decision, pgs. 1-2; PX12).

Petitioner was subsequently diagnosed by Dr. Maday with degenerative changes status post left knee arthroscopy. Petitioner received additional injections by way of visco-supplementation through May 22, 2012; he was released from care on that date with instructions to return as needed. (Arbitrator Flores' 2013 Decision, pg. 2; PX12).

Respondent's Section 12 examiner, Dr. Jeffrey Coe, agreed that the work injury had caused Petitioner's left shoulder and left knee conditions, and that the treatment recommended and thereafter received was reasonable and necessary. Dr. Coe also advised Petitioner that he may require a left total knee arthroplasty in the future. (Arbitrator Flores' 2013 Decision, pg. 2; PX12).

Following the arbitration hearing, Arbitrator Flores awarded Petitioner the medical expenses stipulated to by the parties, as well as 12.5% loss of use of the person as a whole for the left shoulder and 35% loss of use of the left leg in permanent partial disability (PPD) benefits.

On April 6, 2018, the parties appeared before Commissioner Michael Brennan for a 19(h)/8(a) hearing. The issues in dispute were TTD, the amount of an 8(j) credit, and additional permanency for the left leg condition. (T.4-5). At the 19(h)/8(a) hearing, Petitioner's attorney

stated on the record that Petitioner was not seeking any additional recovery for the left shoulder. (T.56).

Following the May 17, 2013 arbitration hearing, Petitioner sought treatment again with Dr. Maday on October 8, 2013. (T.12). The office visit note indicated that Petitioner had been experiencing increasing left knee pain since June, and that he had never been asymptomatic since his discharge. Petitioner's treatment following the May 17, 2013 hearing included an additional injection to the left knee, two rounds of physical therapy, arthroscopic surgery and meniscectomy, and a total knee replacement.

Respondent does not dispute that Petitioner suffered a material increase in his condition, noting that Petitioner's left knee surgery on February 3, 2014, and left knee total replacement on March 11, 2016 were related to the October 19, 2009 injury. The parties' primary dispute is the nature and extent of Petitioner's left leg condition.

As of the date of the 19(h)/8(a) hearing, Petitioner testified that although he no longer had pain from the bone grinding in his left knee, he still experienced swelling, weakness, numbness in the kneecap area, and had pain along the outer side of the knee. Petitioner also continued to wear a knee brace. (T.24-25). Kneeling also caused Petitioner excruciating pain. (T.25). Petitioner walked with a limp. "It swells up on me if I walk too much, or if I stand too much, it will stiffen up on me, and it gives out." (T.26). Petitioner tries to alleviate his condition with ice, elevation, and over-the-counter Tylenol. (T.27).

As to off work benefits, Petitioner testified that from May 17, 2013 up until February 3, 2014, he had not been working. (T.13-14). He stated that he was off work for an unrelated cardiac condition. (T.14). However, Petitioner was still considered an employee of Respondent. (T.14). He had received ordinary disability payments in the amount of $96.45 per day from Respondent during the time he was off work for his heart condition. (T.14). Respondent continued to pay Petitioner ordinary disability benefits through May 24, 2016. (T.22). Petitioner's disability benefits ended on May 24, 2016 because, "I had to retire from the City because I ran out – they ran out of the benefits." (T.23). Thereafter, Petitioner's retirement benefits commenced on August 1, 2016. (T.24).

Petitioner clarified that once he retired, it was his cardiac condition that continued to keep him off work. (T.29). Petitioner stated that he never completed an FCE because he had retired and was not returning to work. (T.32).

Based on the totality of the evidence, the Commission finds that Petitioner has suffered a material increase in his condition pursuant to Section 19(h) of the Act to the extent of an additional 25% loss of use of the left leg.

As to TTD, Petitioner requests benefits from February 3, 2014 through September 8, 2014 and March 11, 2016 through February 14, 2017; on this date, Petitioner's treating physician, Dr.

18IWCC0550

Telly Psaradellis, found that Petitioner had reached maximum medical improvement; this was Petitioner's last visit with Dr. Psaradellis. (T.21; PX5). Respondent claims that the cutoff date should be May 24, 2016; this is the date Petitioner voluntarily retired. (Respondent's Brief, pg. 3).

Our Courts have long held that the determinative inquiry for deciding entitlement to TTD benefits is whether the claimant's condition has stabilized and Petitioner has reached maximum medical improvement. *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 149 (2010). In this claim, Petitioner testified that once he retired on May 24, 2016, it was his chronic cardiac condition that continued to keep him off work. (T.29). Thus, the Commission finds that Petitioner is entitled to TTD from February 3, 2014, the date Petitioner underwent arthroscopic surgery to his left knee. through September 7, 2014, and not September 8, as September 8 was the date Dr. Maday stated that Petitioner could start full duty work. (T.13; T.15-17; PX1; PX3). The Commission further awards TTD from March 11, 2016, the date Petitioner underwent the left knee replacement, through May 24, 2016. By Petitioner's testimony, the Commission finds that Petitioner's work status after May 24, 2016 was unrelated to the work injuries he sustained on October 19, 2009. The total TTD period is 41 5/7 weeks.

The Commission further finds that Respondent is entitled to a credit of $28,163.40, or 41 5/7 weeks at $96.45 per day. By his Brief, Petitioner stated that instead of TTD, Respondent had paid him ordinary disability benefits of $96.45 per day; therefore, Respondent is due a credit towards any award for TTD. (Petitioner's Brief, pgs. 11-12).

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Section 19(h) Petition is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $664.72 per week for a further period of 53.75 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused an additional 25% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $847.84 per week, for a period of 41 5/7 weeks, from February 3, 2014 through September 7, 2014, and from March 11, 2016 through May 24, 2016, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $28,163.40, or 41 5/7 weeks at $96.45 per day, pursuant to Section 8(j) of the Act.

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 other 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 the Circuit Court.

DATED: SEP 7 - 2018

MJB/pm
O: 08-28-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

Jamie Cahue,

Petitioner,

vs. NO: 14 WC 34638

Menasha Packing,

Respondent.

18IWCC0551

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 13, 2018, 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.

18IWCC0551

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 $32,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 7 - 2018
o083018
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

CAHUE, JAIME
Employee/Petitioner

Case# **14WC034638**

17WC007694

MENASHA PACKAGING
Employer/Respondent

18IWCC0551

On 2/13/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% 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:

0815 ACEVES & PEREZ
EMILIANO PEREZ JR
1931 N MILWAUKEE AVE
CHICAGO, IL 60647

0734 HEYL ROYSTER VOELKER & ALLEN
BRAD A ANTONACCI
120 W STATE ST PO BOX 1288
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)

Jaime Cahue
Employee/Petitioner

v.

Menasha Packaging
Employer/Respondent

Case # 14 WC 34638

Consolidated cases: 17 WC 7694

18IWCC0551

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 **01/12/18**. 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, **03/26/2014**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds a causal connection between Petitioner's undisputed accident of March 26, 2014 and his current post-operative right shoulder condition of ill-being. The Arbitrator also finds that Petitioner established causation as to the need for the permanent restrictions imposed by Dr. Tonino. The Arbitrator further finds that Petitioner established causation as to left arm and cervical spine symptoms that warranted imaging and evaluation.

In the year preceding the injury, Petitioner earned **$56,345.12**; the average weekly wage was **$1,083.56**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **4** dependent children.

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

The parties agree Respondent paid Petitioner $28,090.71 in benefits, including a $5,326.88 permanency advance, prior to the hearing of January 12, 2018. Arb Exh 1. RX 9 and 9(a).

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $722.37/week during the following four intervals: December 2, 2014 through January 8, 2015; February 19, 2015 through May 18, 2015; July 20, 2015 through February 7, 2016; and June 27, 2016 through September 22, 2016. Respondent is entitled to credit for the temporary total disability benefits it paid prior to the hearing, per the parties' agreement. Arb Exh 1.

Respondent shall pay the reasonable and necessary medical expenses of Loyola University Medical Center/Dr. Tonino in PX 2(a), subject to the fee schedule and with Respondent receiving credit for the payments it has made per RX 10. Respondent shall pay the $3,500.00 bill of Oak Brook X-ray and Imaging in PX 8(a), subject to the fee schedule.

For the reasons set forth in the attached decision, the Arbitrator finds that Respondent is liable for Section 19(l) penalties in the maximum statutory amount of $10,000.00.

The Arbitrator addresses prospective care in the decision in 17 WC 7694.

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

2/9/18
Date

ICArbDec19(b)

FEB 13 2018

Jaime Cahue v. Menasha Packaging
14 WC 34638 and 17 WC 7649 (consolidated)

Summary of Disputed Issues in Both Cases

18IWCC0551

In 14 WC 34638, the parties agree Petitioner sustained an accident while working as a machine operator for Respondent on March 26, 2014. Petitioner underwent two right shoulder surgeries, in 2014 and 2015, following this accident. He declined to undergo a third surgery (a biceps tenodesis) recommended by Dr. Tonino. The doctor released him to work, subject to several permanent restrictions, on December 19, 2016, following a valid functional capacity evaluation performed at a facility of Respondent's selection.

Petitioner asserts that, at various points during his right shoulder treatment, Respondent gave him tasks that were outside the restrictions imposed by Dr. Tonino. He further asserts he overused his non-dominant left arm while performing those tasks. Respondent disputes these assertions. Petitioner further claims he injured his left shoulder at work on March 10, 2017. This injury is the subject of the second claim, 17 WC 7649.

In 14 WC 34638, the disputed issues include causal connection, medical expenses, temporary total disability during three intervals, penalties/fees, prospective care and underpayment of temporary total disability benefits. In 17 WC 7649, the disputed issues include accident, notice, medical expenses, temporary total disability, penalties/fees and prospective care in the form of left shoulder surgery.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner, age 37, testified he began working as a machine operator for Respondent three years before his undisputed accident of March 26, 2014. Respondent produces customized paper and corrugated products. T. 17-18.

Petitioner testified his job involved operating one half of a machine that was 15 feet long. He had to insert metrics plates and cutting dies in the machine during set-ups to produce products of specific dimensions. A metrics plate is 59 x 42 inches in size and weighs about 450 pounds. T. 19. He also had to use tools, including wrenches and screwdrivers, to set paper size. T. 18-20.

Petitioner testified that, prior to his accident of March 26, 2014, he removed a 450-pound metrics plate from his machine so that he could remove debris from the machine and clean the plate in preparation for the next job. The plate moves along a track that has wheels on both sides. As he attempted to push the plate back into the machine, it fell off the track on the right. At that point, his left hand was on top of the plate and his right hand was underneath it. As the plate tipped, it began to tug his right arm down. T. 21-22. His helper, who was three feet away, and a supervisor came over and attempted to hold the plate up so that Petitioner could extricate his right hand. After Petitioner freed his hand, the plate fell to the floor. Petitioner testified it took a forklift to lift the plate back up. T. 21-25.

Petitioner testified he felt a pop and stinging in his right shoulder when the plate fell to the side. T. 24-25. He immediately reported the injury to Tony, a supervisor. Tony took photographs and escorted Petitioner to an office. Tony then telephoned Dan, an individual Petitioner described as a "therapy guy from Wisconsin" who came to Respondent's facility twice weekly to assess workers. T. 26.

Per instructions received from Dan, Tony told Petitioner to apply ice and Icy Hot to his shoulder and take Tylenol. T. 27-28. Petitioner testified he reported to work during the two weeks following the accident but did not actually perform any tasks. He merely sat in an office, applying ice to his shoulder and taking Advil for pain. T. 29.

Petitioner testified he first sought formal care on April 7, 2014, when he saw Dr. Rodriguez, his primary care physician. Dr. Rodriguez recorded a history of the work accident and noted a complaint of 6/10 right shoulder pain. After performing an examination, he prescribed a right shoulder MRI, with and without contrast, along with a Medrol Dosepak and Norco. PX 1, pp. 3-5. He released Petitioner to work. PX 1, p. 1. T. 29-30.

The MRI, performed without contrast on May 6, 2014, showed no significant effusion, mildly tendonopathic supraspinatus and infraspinatus tendons, without evidence of tearing, and minimal low grade chondromalacia along the anterior margin of the glenoid. PX 1, p. 18.

Petitioner returned to Dr. Rodriguez on May 16, 2014. The doctor again noted a complaint of right shoulder pain. Petitioner testified the doctor recommended he see a specialist. T. 30-31.

Petitioner testified that, during this time period, he was performing various light duty tasks, including sweeping, for Respondent. T. 31.

Petitioner returned to Dr. Rodriguez on August 4, 2014, with the doctor noting a complaint of 5/10 right shoulder pain. On right shoulder examination, the doctor noted a decreased range of motion, tenderness and spasm. PX 1, p. 23. He recommended an orthopedic referral and released Petitioner "to work on a 12-hour shift." PX 1, p. 30.

Petitioner saw Dr. Tonino, an orthopedic surgeon, on September 8, 2014. T. 31. Petitioner initially testified he referred himself to Dr. Tonino. He went on to state that the referral actually came from Dr. Rodriguez. He told Dr. Rodriguez he wanted to see someone at Loyola, which was close to his home, with the doctor suggesting Dr. Tonino. T. 31-32.

Dr. Tonino documented the work accident in his note of September 8, 2014. He noted that a 400-pound plate "yanked [the] right shoulder down." PX 2, p. 11. He described the May 6, 2014 MRI images as "degraded" due to motion. After examining Petitioner and obtaining X-rays, he tentatively diagnosed a labral tear, based on Petitioner's complaints and the mechanism of injury. He prescribed an MR arthrogram. He allowed Petitioner to continue normal work, indicating Petitioner "seems to be doing pretty well with that." PX 2, pp. 4-6.

On September 29, 2014, Dr. Tonino noted ongoing right shoulder complaints. He interpreted the MR arthrogram as showing a tear at the base of the anterior/inferior segment of the glenoid labrum. He recommended arthroscopic surgery. PX 2, p. 20. Petitioner testified that Dr. Tonino took him off work (T. 33) but the doctor's note reflects he released Petitioner to full duty. PX 2, p. 25.

Petitioner returned to Dr. Tonino on November 3, 2014. The doctor noted a complaint of numbness and tingling extending up to the cervical spine and numbness going down the arm to the hand. After noting that Petitioner was scheduled to undergo right shoulder surgery on December 2nd, he referred Petitioner to "Dorothy" for a cervical spine work-up. T. 34. He released Petitioner to light duty with no lifting over 20 pounds. PX 2, pp. 28, 32.

Petitioner saw Dorota Pietrowski, an advanced practice nurse affiliated with Dr. Tonino, on November 4, 2014. Pietrowski documented a history of the work accident. She described Petitioner's symptoms as 50% right shoulder/arm and 50% neck. She indicated Petitioner denied left-sided symptoms. She recommended a cervical spine MRI. She noted that Petitioner "remains off of work" but released him to work. PX 2, pp. 37-39.

The cervical spine MRI, performed without contrast on November 4, 2014, showed mild multi-level degenerative changes without significant central canal or foraminal stenosis. PX 2, pp. 41-42.

On November 19, 2014, Pietrowski reviewed the cervical spine MRI results with Petitioner and suggested he undergo cervical spine therapy after the upcoming right shoulder surgery. She imposed no restrictions relative to the cervical spine. PX 2, pp. 45, 50.

Petitioner testified he did not undergo any cervical spine care at that time. T. 35.

Dr. Tonino operated on Petitioner's right shoulder on December 2, 2014, at Loyola. T. 35. In his operative report, he documented a partial tear of the rotator cuff and a "very complex superior labral tear." He described the biceps tendon as normal. PX 2, pp. 56-57.

On December 8, 2014, Respondent's carrier issued a check in the amount of $739.87 representing temporary total disability benefits from December 2, 2014 (the date of surgery) through December 8, 2014. The carrier continued issuing weekly checks thereafter through January 11, 2015. RX 9.

On January 8, 2015, Dr. Tonino prescribed therapy and released Petitioner to work with no use of the right arm. PX 2, p. 289.

Petitioner testified he began undergoing therapy at Industrial Rehab Allies, a facility selected by workers' compensation. T. 36.

Petitioner further testified that Respondent did not respect Dr. Tonino's restriction that he avoid using his right arm. Instead, Respondent assigned him to dust down pipes and sweep the entire facility, including stacks of skids, using a 3-foot industrial broom. T. 36-37.

Petitioner continued to see Dr. Tonino postoperatively. On February 19, 2015, the doctor noted ongoing right shoulder complaints along with some left shoulder symptoms. He noted the following:

> "With respect to work, apparently they are making him do pretty heavy work with one hand. I am afraid he is going to hurt his other shoulder."

Dr. Tonino administered a right subacromial injection. He directed Petitioner to increase his therapy visits from two to three times per week. He took Petitioner off work "until they can provide more reasonable one-handed work for him." PX 2, p. 313. T. 38.

Respondent's carrier issued weekly checks, each in the amount of $739.87, from February 19, 2015 through March 11, 2015. RX 9.

On March 18, 2015, Respondent's carrier issued a check in the amount of $739.87, representing weekly benefits from March 12 through March 18, 2015, but put a "stop" on this check the same day. RX 9.

On March 19, 2015, Dr. Toninio noted that Petitioner reported minimal improvement from the subacromial injection. He administered an intra-articular injection and directed Petitioner to continue therapy three times per week. He directed Petitioner to remain off work, again noting a lack of reasonable work using one arm. PX 2, p. 328.

Petitioner testified that neither injection provided relief. T. 38-39.

At Respondent's request, Dr. Giannoulias, an orthopedic surgeon, examined Petitioner on April 21, 2015. The doctor's report (RX 1) sets forth a consistent history of the work accident and subsequent labral repair. The doctor noted a history of a left hand fracture.

On right shoulder examination, the doctor noted well-healed arthroscopic incisions, a substantial amount of pain over the acromioclavicular joint with palpation anteriorly and superiorly, pain with cross-arm adduction, popping with elevation past 140 degrees, limited rotation and no pain over the biceps tendon.

The doctor indicated he reviewed a job description and Form 45 in addition to numerous medical records.

The doctor found a causal relationship between the work accident and the labral tear. He further found that Petitioner likely had pre-existing acromioclavicular joint degeneration that was aggravated by the accident. He characterized the treatment to date as reasonable and necessary. He recommended an acromioclavicular injection. While he acknowledged some stiffness of the shoulder, he did not view Petitioner as having a "true frozen shoulder." He believed the stiffness would resolve with four more weeks of therapy. He projected that Petitioner would reach maximum medical improvement within a month or two. He found Petitioner capable of working so long as he avoided all overhead work and any lifting, pushing or pulling over 10 pounds. He did not find Petitioner capable of resuming his machine operator duties. He found no evidence of symptom magnification. RX 1.

On April 21, 2015, Respondent's carrier issued a check in the amount of $739.89 paying Petitioner, retroactively, from March 12 through March 18, 2015. RX 9.

On April 27, 2015, Dr. Tonino noted that Petitioner experienced only transient improvement following the intra-articular injection. He viewed Petitioner as having "some early adhesive capsulitis and possibly some internal derangement." He prescribed an MR arthrogram and kept Petitioner off work. PX 2, pp. 333-334. T. 39-40.

On May 6, 2015, Respondent's carrier issued a check in the amount of $739.87 representing temporary total disability benefits from April 30, 2015 through May 6, 2015. RX 9.

On June 26, 2015, Respondent's carrier issued a check in the amount of $1,268.35 representing temporary total disability benefits from May 7 through May 18, 2015. Respondent did not resume the payment of benefits until mid-September 2015. RX 9.

Petitioner returned to Dr. Tonino on July 6, 2015. T. 40. On re-examination, the doctor noted elevation to 120 degrees on the right, versus 160 on the left, and external rotation to 45 degrees on the right, versus 60 on the left. He noted a delay in obtaining approval for the previously prescribed MR arthrogram. He also noted that Petitioner had experienced an exacerbation since resuming work following a "second opinion." [He did not indicate exactly when Petitioner resumed working]. He recommended that Petitioner perform home exercises pending the MR arthrogram. PX 2, p. 350.

On July 20, 2015, Dr. Tonino interpreted the MR arthrogram as showing a possible recurrent labral tear versus post-operative changes. He recommended revision surgery, noting that Petitioner had "failed conservative treatment." He took Petitioner off work pending the surgery, noting: "we tried sending him back with restrictions but the employer does not accommodate and respect restrictions." PX 2, p. 358. PX 9, Exhibit 3. T. 40-41.

Respondent's examiner, Dr. Giannoulias, issued a supplemental report on August 5, 2015, after reviewing the MR arthrogram and Dr. Tonino's recent records. He interpreted the MR arthrogram as showing that the labrum "has not healed." He again attributed the labral injury to the work accident. Based on Petitioner's current symptoms of numbness and instability, he found a revision arthroscopy and Bankart repair to be appropriate. He anticipated that Petitioner would reach maximum medical improvement six months following this surgery. He recommended that Petitioner be restricted to "light sedentary" work with no lifting over 10 pounds and no overhead activity. RX 2.

On September 15, 2015, Respondent's counsel sent Petitioner's counsel a letter enclosing his appearance and a motion to dismiss. Respondent's counsel indicated it was his understanding that the payment of temporary total disability benefits would resume as of the following day, assuming Petitioner proceeded with the scheduled surgery. PX 9, Exhibit 4.

Dr. Tonino operated again on September 16, 2015, performing a revision labral repair and capsulorrhaphy of the right shoulder. In his operative report, he indicated that it appeared as if Petitioner "had a persistent labral tear which had not healed." He removed two slightly loose sutures and repaired the tear with a revision procedure using four sutures anteriorly to posteriorly. He described the rotator cuff as intact and the biceps tendon as normal. PX 2, pp. 372-373. T. 41.

On September 22, 2015, Respondent's carrier issued a check in the amount of $739.87 representing temporary total disability benefits from September 16 through September 22, 2015. Respondent continued the payment of benefits each week thereafter through October 20, 2015, at which point there was a gap until April 2016. RX 9.

On October 1, 2015, Dr. Tonino noted some complaints of right arm pain. He directed Petitioner to keep his arm in a sling for two weeks and then start therapy twice weekly. He also directed Petitioner to remain off work. He indicated he anticipated keeping Petitioner off work "for a significant time due to a history of the employer not following restrictions on his return to work last time." PX 2, p. 464. PX 9, Exhibit 6.

On October 7, 2015, Respondent's counsel sent Petitioner's counsel an E-mail stating: "we have nothing from you to support your request for any current benefits. Please send if you have anything." PX 9, Exhibit 8.

On October 12, 2015, Respondent's counsel sent Petitioner's counsel another E-mail, stating:

> "Because you are disallowing nurse case management, we need your express authority to contact the treating physician to discuss the modified work duties that we have available.
>
> If we do not receive your express authority by Wednesday, October 7, 2015, TTD benefits will be suspended on Monday, October 19, 2015."

PX 9, Exhibit 7. RX 22.

Petitioner testified he did not begin therapy as directed due to lack of approval. Workers' compensation wanted him to have therapy at Industrial Rehab Allies in Schaumburg but he wanted to go to ATI, which was closer to his home. T. 42.

On November 12, 2015, Dr. Tonino described Petitioner as doing "pretty well" but noted he had not yet started therapy due to "some sort of misunderstanding." He directed Petitioner to remain off work, begin therapy twice weekly and return in six to eight weeks, at which point he planned to address "updated work restrictions." PX 2, p. 474. PX 9, Exhibit 8.

On November 16, 2015, Petitioner's counsel sent "the most recent disability note" (presumably Dr. Tonino's note of the previous day) to Respondent's counsel via E-mail. Respondent's counsel sent the following response later the same day: " . . . look forward to litigating this one with you. He could be working but for your obstructions to modified duty." PX 9, p. 18.

On November 17, 2015, Respondent's counsel sent Petitioner's counsel a letter, via facsimile, advising him that Respondent "has one-handed work available" from 7 AM to 3 PM, Monday through Friday, at Petitioner's "normal hourly rate." Respondent's counsel asked for confirmation that Petitioner would resume working as of November 19th. RX 6. The following day, Respondent's counsel faxed another letter to Petitioner's counsel, acknowledging receipt of Dr. Tonino's restrictions and asking counsel to "advise Dr. Tonino that one-handed work is available," beginning November 19th. RX 6, 23.

Petitioner underwent an initial physical therapy evaluation at Loyola on November 30, 2015. On December 4, 2015, the therapist noted a complaint of "throbbing pain in the anterior shoulder today at rest." He also noted that Petitioner was using an ice pack at home. At the next session, on December 7, 2015, he noted that Petitioner reported moderate pain with elevation of the right shoulder. PX 2, p. 499. At the next two sessions, he noted that Petitioner reported "popping" and sharp pain in the shoulder with elevation. PX 2, p. 501.

On December 30, 2015, Respondent's counsel faxed another letter to Petitioner's counsel, indicating that Petitioner's 19(b) petition was "dismissed" on December 17th. He reiterated the offer of one-handed duty and asked why Petitioner required rescheduling of a Section 12 re-examination from December 22, 2015. RX 6.

At Respondent's request, Dr. Giannoulias re-examined Petitioner on January 5, 2016. In his report, the doctor noted that Petitioner was still complaining of right arm pain and numbness, despite

the recent revision surgery. On re-examination, he noted some supraspinatus atrophy, elevation to about 150 degrees, external rotation to about 50 degrees and some pain with abduction and external rotation. The doctor reiterated his causation finding and recommended four more weeks of therapy. He anticipated that Petitioner would reach maximum medical improvement six to eight months after the revision surgery. He found Petitioner capable of full-time light duty with temporary restrictions of no lifting, pushing or pulling over 10 pounds. He indicated that permanent restrictions were "dependent upon course of healing and response to further therapy." While he described Petitioner as magnifying some of his symptoms with end range of motion, he did not find this inappropriate "for having started physical therapy only six weeks ago." RX 3.

Petitioner returned to Dr. Tonino on January 21, 2016 (T. 42-43), with the doctor noting the therapist's observations. The doctor indicated that external rotation was still limited to 30 degrees but that Petitioner otherwise appeared to be doing well. He also indicated that Petitioner "has had no injuries after surgery." He directed Petitioner to remain off work and continue therapy. PX 2, pp. 508-509.

On January 26, 2016, Respondent's counsel forwarded Dr. Giannoulias' January 18, 2016 report to Petitioner's counsel via facsimile and indicated that Respondent could accommodate the restrictions recommended by Dr. Giannoulias. Counsel also indicated that one-handed work was "still available," referencing prior offers of such work on November 17 and 18, 2015 and December 30, 2015. RX 6.

On January 29, 2016, Amanda Faust, Respondent's human resources manager, wrote to Petitioner indicating that Respondent had work available within the restrictions recommended by Dr. Giannoulias and directing Petitioner to report to work on February 8, 2016. Faust informed Petitioner that, if he failed to report on said date, Respondent would begin counting his absences as occurrences against its attendance policy. RX 7. Respondent's counsel forwarded a copy of Faust's letter to Petitioner's counsel the same day and asked for permission to contact Dr. Tonino for the sole purpose of asking him whether Petitioner could perform modified or one-handed work. RX 8.

Under cross-examination, Petitioner testified he returned to work in February 2016. T. 83.

On March 10, 2016, Dr. Tonino that Petitioner was still experiencing popping in the shoulder when lifting. He again noted limited external rotation. He indicated Petitioner "will continue with work restrictions for his right arm." He directed Petitioner to continue therapy. PX 2, p. 511.

Petitioner acknowledged asking Dr. Tonino to release him to full duty on March 10, 2016. He made this request because he was not receiving benefits. T. 43. He did not, however, actually resume full duty. Respondent "had [him] showing another operator how to operate the machine." T. 46.

Petitioner saw Laura Thometz, PA-C, at Loyola on April 1, 2016. Thometz noted that Petitioner was performing light duty and complained of increased right shoulder pain with lifting as well as numbness and tingling in the entire right arm during the preceding three weeks. She also noted that Petitioner denied neck pain or any acute injury to the shoulder. On examination, she noted tenderness over the right acromioclavicular joint and right anterior shoulder and pain with Jobe's and O'Brien's testing. She directed Petitioner to continue his home exercises and see Dr. Tonino. She continued the previous restriction of no right arm usage. PX 2, p. 516.

Petitioner saw Dr. Tonino on April 4, 2016, and complained of popping in the right shoulder and difficulty elevating beyond 120 degrees. The doctor also noted that Petitioner complained of numbness and tingling in the right arm with right-sided lateral neck pain. He released Petitioner to work with no lifting over 10 pounds and no overhead or repetitive usage of the right arm. PX 2, p. 517. T. 44.

Petitioner testified that, after he presented the April 4, 2016 restrictions to Respondent, he was assigned to the task of removing a 2-inch layer of glue from a piece of steel pipe that was 9 feet long. He had done this job in the past and knew it required the use of both hands. He told human resources he could not perform this job. Respondent assigned other work to him. T. 46-47.

On April 7, 2016, Respondent issued a check in the amount of $5,324.04 representing disputed temporary total disability benefits from October 21, 2015 through December 20, 2015. RX 9.

At the next visit, on April 21, 2016, Dr. Tonino noted persistent complaints. He recommended another MR arthrogram and released Petitioner to work with no right arm usage. PX 2, p. 518. T. 48.

Petitioner testified that Respondent then assigned him to "unstacking and restacking skids." This involved sorting through and moving stacks of misprinted boxes and bundles of "E-Flu" paper. Petitioner described the "E-Flu" paper as a "top of the line," heavy paper. He testified that 25 sheets of this paper can weigh up to 30 pounds, "including the glue." Each "E-Flu" bundle contained 25 sheets. He had to transfer the boxes and "E-Flu" bundles from skids to a table and from the table to skids. The table was about 3 feet high. He used only his left hand and arm to move the bundles, cut the string around each bundle and sort through the boxes and paper. T. 49-50. This job lasted three months. He finished three to five skids per day, with each skid containing 24 to 25 bundles. T. 50.

The repeat right shoulder MR arthrogram, performed on May 10, 2016, showed contrast insinuation into the inferior labrum, "consistent with a tear," as well as tendinosis of the intra-articular biceps tendon, extension of contrast between the infraspinatus and supraspinatus tendons and mild acromioclavicular joint osteoarthritis. PX 2, pp. 512-513. T. 51.

On May 16, 2016, Dr. Tonino interpreted the MR arthrogram as likely showing post-operative changes rather than anything new. He noted that most of Petitioner's pain was "anteriorly near the biceps tendon." He prescribed additional therapy along with a Medrol Dosepak. He continued the previous restriction of no right arm usage. PX 2, p. 519.

On June 27, 2016, Dr. Tonino noted complaints of pain in both shoulders. He noted that, while Petitioner had been directed to avoid using his right arm, he was "doing work with both arms . . . but using primarily his left shoulder." On examination, he noted tenderness over the bicipital groove bilaterally, elevation to 120 degrees bilaterally and normal rotator cuff strength bilaterally. He took Petitioner off work pending a functional capacity evaluation. PX 2, pp. 520-521. Petitioner testified that Dr. Tonino prescribed this evaluation after he declined to undergo a third right shoulder surgery. T. 51.

Petitioner underwent a functional capacity evaluation at Industrial Rehab Allies on July 8, 2016. Petitioner testified that Respondent's carrier set up this evaluation. T. 52. The evaluator, Steve Adamkiewicz, M.S. [hereafter "Adamkiewicz"], rated the evaluation as valid. He found that Petitioner "demonstrated work tolerance at the light-medium physical demand level" and that his BOBST operator job was rated at a medium physical demand level. He referenced both Petitioner's description of his job duties and a job analysis provided by Triune Health Group rating the BOBST job at the medium physical

demand level "due to the occasional need to lift a 35-40 lb. cutting die and frequent feeding of handfuls of sheets into the hopper weighing 25 to 30 pounds." PX 6, p. 7. He suggested that Petitioner undergo work conditioning to increase his tolerance. He noted that Petitioner reported "experiencing left shoulder pain since working light duty" and complained of constant right proximal biceps pain. PX 6. At the hearing, Respondent offered into evidence a report from Rachel K. Viel, MS, PT [hereafter "Viel"] dated October 11, 2016, in which Viel concluded she could not determine whether the functional capacity evaluation results were truly valid, "due to the limitations of validity testing." RX 16.

On August 4, 2016, Dr. Tonino noted the results of the functional capacity evaluation. He also noted that Petitioner was still experiencing left shoulder pain. He recommended work conditioning. He directed Petitioner to remain off work and return in six weeks. T. 52. PX 2, p. 522. T. 52. In her report of October 11, 2016, Viel concluded that it was reasonable for Petitioner to undergo work conditioning for two to four weeks, with the goal of improving his frequent material handling tolerances. RX 16.

Based on records and correspondence in PX 6, it appears Petitioner began attending work conditioning at Industrial Rehab Allies in Lombard on August 16, 2016 but began cancelling sessions as of August 22nd "because he did not have any gas money." Adamklewicz wrote to Dr. Tonino on September 16, 2016, indicating that, with the encouragement of the workers' compensation carrier, Petitioner had started attending sessions at a different facility closer to home but began experiencing left upper extremity shooting pains after two sessions. Adamklewicz advised Dr. Tonino that Petitioner was scheduled to undergo a spinal evaluation. Adamklewicz also noted, correctly, that Petitioner had not received any workers' compensation benefits "for months."

Records in PX 7 reflect Petitioner began a course of work conditioning at ATI Physical Therapy on August 29, 2016. On September 6, 2016, Christopher Sullivan, ATC, reported to Dr. Tonino that Petitioner began the program at a light physical demand level and was "starting to feel increased pain in his other [i.e., left] shoulder with activity." Sullivan also noted that Petitioner's machine operator job was considered a medium physical demand level job, with occasional lifting of 50 pounds, based on the Dictionary of Occupational Titles.

On September 9, 2016, Petitioner saw Laura Thometz, PA-C, Dr. Tonino's assistant. T. 53. Thometz noted that Petitioner had started work conditioning at "RARA" but had switched to ATI, which was closer to him. She indicated this was "progressing well until yesterday," at which point Petitioner "woke up with his entire left arm . . . cold and numb." She noted that Petitioner felt he "may have overdone it in work conditioning." On left upper extremity examination, she noted pain with impingement maneuvers and rotator cuff testing. She directed Petitioner to hold off with work conditioning until he could be evaluated by a spine specialist. PX 2, pp. 523-524.

On September 12, 2016, Sullivan reported that Petitioner reported having increased pain with "lift and carry" exercises and was complaining of increased numbness in his left forearm and "the same pain in his right arm." PX 7, pp. 1-2.

On September 14, 2016, Petitioner returned to Dorota Pietrowski, RN, MSN, at Loyola. She noted that Petitioner reported developing radiating left arm symptoms on September 7th. She also noted that Petitioner had been undergoing work conditioning but denied any specific accident or injury. On examination, she noted numbness in the left forearm. She diagnosed cervicalgia with possible left arm radiculopathy. After reviewing the 2014 cervical spine MRI, and noting that Petitioner's symptoms were right-sided at that time, she recommended a new cervical spine MRI. PX 2, p. 525.

On September 22, 2016, Dr. Tonino noted that Petitioner developed left arm symptoms while participating in work conditioning and was still experiencing right shoulder symptoms. He also noted the cervical spine MRI recommendation. He released Petitioner to work with no lifting over 10 pounds and no overhead or repetitive use of the right arm. PX 2, p. 532.

At Respondent's request, Dr. Giannoulias examined Petitioner a third time on October 18, 2016. In his report, he noted ongoing right shoulder and arm symptoms. On right shoulder re-examination, he noted no pain to palpation of the acromioclavicular joint, no crepitation, elevation to about 160 degrees, external rotation to 40 degrees, internal rotation to the upper buttock, 4+/5 strength, no instability and pain with end range of motion. He noted no abnormalities on left shoulder examination.

Dr. Giannoulias indicated he reviewed additional records from Dr. Tonino, the functional capacity evaluation report, a description of a BOBST operator job and a video "of the quality position [Petitioner] more recently was working in." He found the activities in the video "not consistent with causing an overuse injury of the upper extremities." With respect to the right shoulder, he diagnosed post-operative capsulitis from the labral repair and a healed labral tear. He did not diagnose any left shoulder condition, based on his negative examination. He did not link Petitioner's left shoulder complaints to either the work accident or the duties shown on the video. He related only the right shoulder treatment to the accident but characterized all of the treatment as reasonable and necessary. He did not believe Petitioner required more care for either shoulder. He described Petitioner's prognosis as fair. He recommended that Petitioner resume full-time work subject to the permanent light to medium restrictions established by the functional capacity evaluation. Based on the video, he believed Petitioner could perform work duties in Respondent's quality division. He did not believe Petitioner could resume his original machine operator job. RX 4.

On October 24, 2016, Dr. Tonino noted complaints of left-sided neck pain radiating to the left shoulder, right shoulder pain and right arm numbness. He noted no gross neurological abnormalities on examination. He indicated Petitioner still needed to see a cervical spine specialist. He continued the previous restrictions. PX 2, p. 533.

The cervical spine MRI, performed without contrast on November 8, 2016, showed mild spondylitic changes "without gross disc protrusion, spinal stenosis or foraminal stenosis at any cervical level." PX 8, pp. 1-2.

On November 28, 2016, Dr. Tonino noted that Petitioner had undergone the cervical spine MRI but had not yet seen a cervical spine specialist. After noting persistent cervical spine complaints, he again recommended a cervical spine consultation. PX 2, p. 535.

Petitioner testified he underwent a left shoulder MRI at Dr. Tonino's recommendation on December 9, 2016. T. 54.

On December 19, 2016, Dr. Tonino noted ongoing bilateral shoulder complaints. He recommended only conservative care for the left shoulder, based on the MRI and degree of symptoms. He found Petitioner to be at maximum medical improvement with respect to his right shoulder. He imposed permanent restrictions of no lifting over 10 pounds and no overhead or repetitive use of the right arm. PX 2, p. 536. T. 54-55.

Petitioner testified he presented the permanent restrictions to Respondent after December 19, 2016. He further testified Respondent did not honor these restrictions. He was assigned to the task of putting various tubes into designated slots that were overhead. The tubes were made of paper. They were 6 to 8 feet long. Each weighed "maybe two to three pounds tops." T. 56. Petitioner testified he had to use an 8-foot ladder to access the slots. He had to move the ladder back and forth all day long to get to the correct slots. T. 56-57. He also had to stack and restack skids, as he had done in the past. T. 57.

Petitioner testified he returned to Dr. Tonino on January 30, 2017. The doctor administered a right shoulder injection and modified his restrictions to no lifting over 5 pounds and no repetitive or overhead use of the right arm. T. 58.

Petitioner testified that Respondent did not honor Dr. Tonino's modified restrictions. Respondent again assigned him to stacking and restacking skids. T. 59.

Petitioner testified that, prior to his claimed accident of March 10, 2017, he was assigned to the task of breaking down flaps of "E-flu" paper. He testified he had to work under time pressure because the customer needed the paper as soon as possible. He had "eight units" of skids to work on, with each skid holding up to 7200 pieces. T. 59. For three days, he worked alone at a table that was 3 feet high. He had to grab the paper, place it on the table, stabilize it with his right hand and press down with the palm of his left hand, using the edge of the table to break the flaps. There were about eight flaps on each side of the paper. He had to press "as hard as [he] could," using his body weight, to break the flaps evenly. T. 61, 63. After doing this for three days, "working as quickly as possible," he was given two helpers "for the second unit." He testified the helpers were not able to break the flaps using their hands and body weight. They had to use screwdrivers and hammers. T. 62. He was not able to use any tools because he would have had to use them with his dominant right hand and the work would have exceeded his restrictions. T. 63.

Petitioner testified that, on March 10, 2017, he was working alone again, on the third unit, performing the same task. As he pushed down on a flap, using his left palm, he felt a pop and stinging sensation in his left shoulder. T. 64. He tried to resume working but was not able to do so. T. 64. He went to the office and reported his injury to three people: John Beyers, a supervisor, "Phil," the quality control superintendent and "another lead person" whose name he was not sure of. T. 66. Beyers completed an accident report the same day. T. 65. Beyers gave Petitioner four ice packs to apply to his left shoulder. Petitioner testified he did not perform any additional work that day. T. 65-66.

Petitioner returned to Dr. Tonino on March 13, 2017. T. 66. The doctor noted that, on March 10th, Petitioner "had another injury to his left shoulder when he was moving some materials and felt a pop and immediate stinging in his left shoulder." He also noted that Petitioner "took Vicodin with no improvement." On examination, the doctor noted elevation to about 120 degrees bilaterally, some pain with rotator cuff testing and some pain with resisted testing of the left biceps. He suspected a left labral tear. He recommended an MR arthrogram of the left shoulder and took Petitioner off work. He informed Petitioner he might require left shoulder surgery. PX 2, p. 538. T. 66-67.

The MR arthrogram, performed on April 4, 2017, showed a supraspinatus tendon tear with an articular-sided tear extending into the intrasubstance delamination and a full-thickness tear extending from the intrasubstance tear to the bursal surface. The radiologist noted no biceps or labral abnormalities. PX 2, pp. 550-551.

On April 10, 2017, Dr. Tonino noted ongoing left shoulder symptoms. He reviewed the MR arthrogram with Petitioner and recommended surgery, indicating Petitioner might need a biceps tenodesis as well as a rotator cuff repair "based on what he had in his right shoulder." PX 2, p. 553. PX 9, Exhibit 9. T. 67.

On June 8, 2017, Dr. Tonino noted that Petitioner remained symptomatic and had not received approval for the recommended left shoulder surgery. On re-examination, he noted pain with resisted palmar abduction with rotator cuff testing. He directed Petitioner to remain off work pending surgery. PX 2, p. 554.

At Respondent's request, Dr. Giannoulias examined Petitioner a fourth time on July 11, 2017. In his report, he indicated that Petitioner described feeling a pop and injuring his left shoulder on March 10, 2017, while tearing a box apart. He also indicated that Petitioner denied having any left shoulder problems prior to that incident. He reviewed the left shoulder MRI images, the Form 45 concerning the left shoulder injury and Dr. Tonino's recent records.

On left shoulder examination, Dr. Giannoulias noted crepitation with abduction and internal rotation, pain with resisted elevation, weakness at 4-/5 and positive Neer's and Lachman's.

Dr. Giannoulias diagnosed Petitioner as having a full-thickness left rotator cuff tear. He attributed this injury to the work accident of March 10, 2017, noting that "no other injury occurred from either the medical records or the examinee's history." He described the tear as acute, based on the MRI images. He characterized the treatment to date as reasonable and necessary. He agreed with Dr. Tonino's recommendation of a left rotator cuff repair. He found Petitioner capable of working so long as he avoided lifting, pushing or pulling more than 5 pounds or performing any overhead work with his left shoulder. He attributed the need for these restrictions to the March 10, 2017 accident. RX 5.

On July 11, 2017, Dr. Tonino noted ongoing left shoulder symptoms. He indicated he was awaiting authorization of the previously recommended surgery. PX 2, p. 555.

On July 28, 2017, Dr. Giannoulias issued a supplemental report, after reviewing surveillance video footage obtained on April 20 and 22, 2017 and certain Facebook photographs. He indicated that the video merely showed Petitioner walking. To him, "it did not appear that [Petitioner] was doing anything substantial outside of his restrictions with his left shoulder." He stated that the opinions he expressed in his last report were unchanged. RX 5.

Petitioner's counsel filed a 19(b) petition and petition for penalties and fees on August 28, 2017. PX 9.

On August 31, 2017, Dr. Tonino noted [apparently incorrectly] that surgery had "finally been approved." He reiterated that there might be biceps as well as rotator cuff involvement. PX 2, p. 556.

Petitioner testified he wants to undergo the left shoulder surgery recommended by Dr. Tonino. He has received no temporary total disability benefits since the March 10, 2017 accident. He has not undergone any conservative care, such as therapy, for his left shoulder. T. 68-69.

On September 26, 2017, Dr. Giannoulias issued a supplemental report, after reviewing Dr. Tonino's most recent records, the left shoulder MR arthrogram and surveillance videos from April and May 2017. Dr. Giannoulias agreed with Dr. Tonino that the left shoulder MR arthogram showed a full-thickness rotator cuff tear. He also agreed with Dr. Tonino's recommendation of a left rotator cuff repair. He indicated the videos added nothing to his opinions since they showed no engagement of the left shoulder. He changed his previous causation opinion based on what he perceived as a "discrepancy in regards to the history." Specifically, he concluded that, because Petitioner had told him at the last examination that he had no left shoulder pain before the March 10, 2017 accident, and because the records showed otherwise, the left rotator cuff pathology was "a manifestation of a pre-existing condition." He indicated that, "regardless of causation," Petitioner required no restrictions with respect to the left shoulder. RX 25.

On September 27, 2017, Respondent issued a check in the amount of $5,326.88. This check represents a permanency advance. RX 9(a).

Respondent filed a response to Petitioner's penalties and fees petition on October 10, 2017. RX 27.

Under cross-examination, Petitioner acknowledged injuring his left hand on January 16, 2005, while working for Flying Food Fare. A cart fell onto his hand. He required surgery and has six screws in the palm of his left hand. He did not injure any other body parts. T. 69.

Petitioner acknowledged working between his March 26, 2014 accident and his December 2014 right shoulder surgery. T. 70. Following the surgery, he returned to work in January 2015, after Dr. Tonino released him to work with no use of the right arm. T. 71. At that point, he worked in Respondent's quality department. When he returned to Dr. Tonino on February 19, 2015, he told the doctor Respondent was making him perform heavy work. T. 71. The doctor took him off work. The doctor told him to avoid any activities involving significant use of his arms. He followed this advice in the spring and summer of 2015. [At this point in the hearing, Petitioner was shown a portion of surveillance video obtained by Respondent on July 4, 2015. This portion shows Petitioner washing a vehicle. A 20-second segment shows Petitioner using his left hand to scrub a wheel and his right hand to lean against the vehicle. Another segment shows the reverse. T. 75-76. At another point, he uses his left arm to reach overhead to clean the top of the vehicle. He also climbs up on the vehicle to use his right arm to reach out from shoulder level. At another point, he carries a bucket which he testified contained only soap and no water. T. 78. Later in the video, he reaches overhead to use a pressure washer and uses both arms to wipe down the vehicle. T. 78-79.]

Petitioner testified he was not subject to any restrictions with respect to his left arm as of 2015. T. 80.

Petitioner testified he returned to light duty in May 2015. He acknowledged he never asked Dr. Tonino whether he could perform one-handed work. T. 81. He kept advising the doctor that Respondent was not accommodating his restrictions. T. 81.

Petitioner testified he typically travels to Mexico at the end of each year, for the holidays. He did not have to change the date of a Section 12 re-examination due to this travel. It was Respondent that kept changing the schedule of the appointment. T. 83.

Petitioner was not sure whether Respondent offered him light duty in January 2016. He did return to work in February 2016. T. 83. At that point, he was assigned to stacking and restacking in the quality department. He also had to go around the facility to check on broken glass, paint quality, etc. T. 84. Respondent told him he could work at his own pace while stacking and restacking but sometimes the customer needed the order as soon as possible, which meant he "had to work faster." T. 84. Respondent did not advise him to stop working if he experienced symptoms. To the contrary, Respondent told him to keep working, saying "you still have one good left arm." T. 84. Some of the light duty he performed consisted of walking around the facility, checking on tooling and measuring tapes with a ruler. T. 85. He agreed this work was not strenuous. T. 86. He also opened a cabinet to check to see whether chemicals and tools were tagged. This was also not strenuous. T. 87. With respect to the stacking and restacking, there was never a time when he simply monitored other workers performing this activity. He was always physically involved in this work. He was able to do this work one-handed. The dusting and cleaning he performed took place "maybe two times a week." He used his left hand to do this work. It would take the entire shift because there are a lot of pipes in the facility. T. 88. With respect to the "breaking flaps" job, Respondent did not tell him he could stop whenever he felt the need to. The job had to be done as quickly as possible. T. 90-91. The ladder he used while putting tubes in slots had wheels. T. 92. He spent most of his light duty time sitting, waiting for assignments. He would ask his supervisor for work. T. 92. During each shift, he was allowed to take a 20-minute lunch break, two 10-minute breaks and one 5-minute break, per union rules. T. 93.

At this point in the hearing, Respondent's counsel showed various job-related videos. Petitioner does not appear in these videos. Petitioner testified that Image 3752 shows the sorting area where he performed stacking and restacking. The bundles he worked on were composed of "mixed sheets," i.e., pieces of paper of different sizes. He could not always flip each sheet. He could do some of the work one-handed, but it depended on the size of the sheet he was dealing with. T. 100. Petitioner testified that Image 1629 shows a worker breaking down flaps. Petitioner testified the video makes the job look easy because the worker is breaking flaps on paper that was not nicked. In contrast, he worked on paper that was nicked, meaning it had been cut into to prevent jamming. He agreed it would not take much force to break flaps on paper that was not nicked. T. 104. He attributes his March 10, 2017 accident to working on paper with "heavy nicking." T. 105. Image 1631 shows a full sheet of tabbed paper. Petitioner testified it is not easier to break flaps or tabs on one sheet at a time. It is actually easier to work on several sheets at a time. If you just take one sheet and try to bend the flaps, "the whole edge" bends in. T. 105-106.

After looking at RX 19, consisting of two forms charting the tasks he performed during two weeks in September and October 2016, Petitioner agreed the tasks were not strenuous. T. 112.

Petitioner acknowledged telling Dr. Giannoulias in September 2017 that he did not have left shoulder symptoms before the March 10, 2017 accident. It was his understanding, based on a letter he received, that the doctor had received all of the information he needed. T. 113. His left shoulder symptoms began in 2015. He saw Dr. Tonino for his left arm in September 2016 and denied any specific accident. T. 113-114. After the March 10, 2017 accident, he felt a pop and stinging in his left shoulder. He was not able to work after the accident. He went home and took a Vicodin. Later that night, his wife threw him a surprise birthday party. T. 115. He identified one of the photographs in RX 20 (page 2) as a photograph of him holding his baby daughter. This photograph was taken late at night on March 10, 2017. His wife was behind him, holding his daughter up. T. 116.

Petitioner testified he has not worked since March 2017. He has not looked for work elsewhere because he is supposed to be employed by Respondent. T. 117. During the times he performed light duty for Respondent, he would sometimes ask to stop due to symptoms. He was not always allowed to stop. Sometimes the customer needed the product and he had to keep working. T. 117-118.

Petitioner testified he has had no right shoulder treatment since December 2016. T. 118.

On redirect, Petitioner testified that Respondent changed the date of a Section 12 re-examination to a day when he was already scheduled to be off for vacation. T. 118. He notified human resources of this since, if he did not take the vacation day as scheduled, he would lose his pay for that day. T. 119. Phil was the only person who gave him light duty assignments. T. 119. During down time, when he was between assignments, he would repeatedly ask Phil and Barbara, Phil's assistant, for work. T. 120. He did not decline any assignments other than the glue removal assignment. T. 121. The party his wife threw for him took place on the night of March 10, 2017. At that time, his daughter was one year old and weighed about ten pounds. He carried her that night for no more than ten to fifteen seconds. He did not lift anything else that night. T. 121-123.

Under re-cross, Petitioner testified the ladder shown in the photographs marked as RX 26, A through E, is not the ladder he used. The ladder he used was eight feet tall. It had wheels. T. 123-124.

Barb Quiroz testified on behalf of Respondent. Quiroz testified she has worked for Respondent for almost ten years. She handles "hard cards," or orders, and customer complaints. She also keeps track of production die cut. T. 128-129.

Quiroz testified she knows Petitioner. She oversaw the light duty work Petitioner performed between 2015 and 2017. T. 129. She gave assignments to Petitioner 90% of the time. T. 131. She and Petitioner worked from 7 AM to 3 PM. Her cubicle was about ten steps away from the desk where Petitioner worked. She could see Petitioner sitting at his desk because the walls of her cubicle were not high. T. 131. Between 2015 and 2017, Petitioner's light duty tasks varied. He put "hard cards" in order, oversaw track numbers, took "low tags" to the office and made lists of workers who performed certain tasks. He also performed audits once a day. This involved walking around while carrying a clipboard and writing serial numbers. He also checked the pH levels once a month. This involved holding a small cup and opening a cabinet door. The audits and pH checks were not strenuous. T. 135. Petitioner also performed sorting. When customers returned paper products that were defective, he separated those products into stacks. The heaviest item he might have handled while sorting was a three-shelf Frito display box that maybe weighed two pounds. T. 136. Once monthly, Petitioner might have been given a rag and told to dust down surfaces, including railings. T. 137. This was not strenuous. Quiroz had no recollection of Petitioner using an industrial mop or broom. T. 138. Petitioner also used a knife to cut bands and peeled shrink wrap off bundles. This was not strenuous. Petitioner also broke flaps on craft boxes. There were two flaps on each side of these boxes. If the "nicks" on the boxes did not break through, you would break the flaps manually. The flaps were not big. No one used tools to break them because, nine times out of ten, that would have caused damage to the box. T. 139-140. Petitioner was told to use his own judgment as to how many to break at one time. Petitioner knew his limitations. "We didn't go out there and watch him the whole time." T. 140. She told him to work at his own pace and take breaks as needed. He was not required to meet any quotas or work at a set pace. T. 142.

Quiroz testified Petitioner spent about an hour or two each day clearing up used Mylar sheets. This involved going to the centers where Mylar was used, rolling a cart to the label room and sliding

tubes into racks. Petitioner was not required to work overhead while doing these tasks. Wheeled ladders were available to him. Pushing one of these ladders was like pushing an empty stroller. Quiroz testified that the photographs marked as RX 26, A through E, show Mylars on racks and a 2-step ladder. T. 145-146.

Quiroz testified that Petitioner spent most of his light duty time in an office, where he used his cell phone or simply "chilled." T. 147.

Quiroz testified she was familiar with Petitioner's restrictions. Petitioner was never asked to exceed those restrictions. The job videos accurately show the light duty tasks Petitioner performed. If Petitioner complained of symptoms, he was not told he had to keep working. Petitioner did not turn down assignments. T. 148.

Under cross-examination, Quiroz testified that Phil Sopicki is Respondent's quality control manager. Sopicki is her boss. Sopicki assigned tasks to Petitioner in her absence. T. 150-151. An upper manager, Mark Welk, is the person who gave her the job of overseeing Petitioner's light duty. When Petitioner performed sorting, he went through boxes to check for defective products. The boxes were bundled ten percent of the time. They were on skids that were 48 inches tall or lower. She has performed sorting but is not sure of the weight of the heaviest bundle. While Petitioner was on light duty, he both observed and performed stacking. T. 153. Petitioner was a good employee. He was helpful to her. He took on all tasks that were assigned to him. Petitioner's assignments emanated from the quality control department but he traveled to other areas to perform those assignments. T. 154.

Quiroz testified she is not familiar with Respondent's "temporary transitional work schedule." She identified the two documents in RX 19 as forms that light duty employees completed and turned in. Phil would sign off on these forms. She could not recall signing off on them. T. 155-156.

On redirect, Quiroz testified that, if an order was banded, it was necessary to cut the band off before removing defective products. She described the bands as "real thin" and made of plastic. T. 158. There were "nine stacks of tens" in each layer. T. 159. Petitioner used his own judgment as to how much weight to lift at any one time. T. 159, 161. Petitioner did not lift anything that weighed more than 5 pounds. T. 161. One box could weigh one pound. No tasks in the quality department involved steel pipes. T. 161.

Emilio Diaz also testified on behalf of Respondent. Diaz testified that Respondent makes corrugated paper and boxes as well as "litho displays." T. 165. He has been Respondent's area manager for two or three years. He oversees, automotons, gluers and safety-related issues. Before that, he was a maintenance manager. That job involved repairing and maintaining the machines and facility. T. 164.

Diaz testified he knows Petitioner. T. 165. Petitioner used to work as a "Bobst" operator for Respondent. He and Petitioner did not work in the same department. T. 166. He (Diaz) used to operate a "Bobst" machine. The job involved setting up jobs and dies according to customers' specifications and running product through the machine. A forklift operator brought materials to the "Bobst" operator. T. 166-167.

Diaz testified he has previously seen RX 28, an analysis of the "Bobst" operator job. T. 168. The job functions and machinery and tools listed on the first page of RX 2 are accurate. The physical demand levels listed on the second page are "pretty much" accurate but some of the percentages are off. T. 169.

A "Bobst" operator spends 1 to 10%, not 30%, of his time kneeling. The 60% assembly percentage is "too high." An operator has to assemble a box only once for each job. The statement as to the heaviest weight lifted, i.e., 25 to 30 pounds, is accurate. The die cast weight range, i.e., 15 to 50 pounds, is also accurate. However, there are two types of "Bobst" machines: small and large. Some of the lifting-related statements on the last page are not accurate. It is not accurate to say an operator never lifts anything weighing less than 10 pounds because "some orders are really small." It could be accurate to say an operator spends 3 to 4 hours per day lifting between 25 and 50 pounds. The carrying-related information, i.e., that an operator spends 1 to 2 hours per day carrying 25 to 50 pounds is "very close" in terms of accuracy.

Diaz had no recollection of Petitioner being assigned to scrape glue off of a pipe around April 2016. Glue is used in the automaton department and with the "posting gluers." T. 173. Diaz testified he took over the automaton department in early 2016. He does not recall Petitioner being there. He mainly works from 7 AM to 3 PM but sometimes works overtime. T. 173-174.

Under cross-examination, Diaz testified he did not create RX 28. He first saw this document a week before the hearing. RX 28 is "very close" to but not the same as the document that is used at Respondent's plant. T. 175. He does not know the weight of a flat bed plate. The plate is on a wheeled track. T. 176-177. It was not directly his job to assign tasks to Petitioner. T. 177.

As noted above, Respondent offered into evidence Petitioner's "temporary transitional work schedule" for the weeks of September 26, 2016 and October 24, 2016. The schedule for the week of September 26th bears Petitioner's notes, initials and signature. The schedule for the week of October 24th also bears the initials of Phil Sopicki. On one day, September 27, 2016, Petitioner was off work due to having to go to court. On the remaining nine workdays, Petitioner indicated he performed various tasks, including checking linear tape, cleaning up a "hold" area, unstocking and restocking skids, putting "hard cards" away, discarding old "mylars" and marking print plates. Petitioner did not describe the precise physical demands of these tasks on the forms. RX 19.

Arbitrator's Credibility Assessment Relative to Both Cases

Petitioner came across as a hard-working individual. The Arbitrator finds credible his testimony that some of the work Respondent directed him to perform was beyond his restrictions. Respondent's witness, Barbara Quiroz, conceded that Petitioner received approximately 10% of his assignments from her boss, Phil Sopicki. Sopicki did not testify. Quiroz also conceded it was Sopicki who signed off on Petitioner's "temporary transitional work schedules" (RX 19). She further acknowledged that Petitioner performed some of his assigned duties outside of the quality control department where she was based. She described Petitioner as a good employee who was helpful to her.

It is the detailed nature of Petitioner's testimony about his assignments that the Arbitrator finds compelling. For example, Petitioner took issue with the portion of Respondent's job video (RX 18, Image 1629) that purportedly showed the "flap" job. He testified the activity looked "easy" on the video because the flaps were not "nicked." The flaps he broke down were "nicked" and the material was heavier. He described a specific three-day interval during which he worked alone, breaking down flaps quickly because of a "time crunch" with the underlying order. Quiroz indicated Petitioner was always allowed to work at his own pace but that testimony is in conflict with Petitioner's testimony that, after the first three days, during which he worked on 7200 pieces, Respondent assigned two people to help him. Those two people ended up having to use hammers or screwdrivers to break down the flaps. T.

62-63. Petitioner could not work in this fashion due to his one-handed restriction. Petitioner's description of the "tubes" job was also detailed and persuasive. While the tubes were not at all heavy, as Petitioner readily conceded, they were 6 to 8 feet long and had to be placed in specific slots. Petitioner testified the slots were above shoulder level. It makes sense to the Arbitrator that Petitioner could have taxed his left arm while working off of a ladder to guide each tube into the correct slot. It also makes sense that Petitioner could have taxed both arms while moving and unbundling sheets of "E-Flu" paper. Neither of Respondent's witnesses contradicted Petitioner's testimony as to the special qualities and weight of this paper.

On only one occasion did Respondent's examiner note any symptom magnification. He described that magnification as "insignificant," given that Petitioner had recently undergone surgery.

Petitioner's testimony concerning his March 10, 2017 accident was also detailed and credible. He testified he provided three supervisors of the accident the same day it occurred. He identified two of these supervisors by name. Neither of them appeared at the hearing. Additionally, the history Dr. Tonino recorded on March 13, 2017 is consistent with Petitioner's account of the accident.

Respondent contends Petitioner was not forthright with Dr. Giannoulias with respect to the timing of the onset of his left shoulder symptoms. In support of this contention, Respondent points to the doctor's re-examination report of July 11, 2017, in which he indicated that Petitioner denied having any left shoulder pain prior to the March 10, 2017 accident. When Petitioner was asked about this at the hearing, he indicated he believed Dr. Giannoulias had reviewed all of his records, since he had already seen the doctor several times. The Arbitrator notes that, when Dr. Giannoulias re-examined Petitioner in October 2016, he was clearly aware that Petitioner's shoulder symptoms were now bilateral. In fact, he specifically addressed causation vis-à-vis the left shoulder. It makes no sense to the Arbitrator that Petitioner would have denied having left shoulder pain before the March 10, 2017 accident when the doctor had already addressed his left shoulder complaints months earlier. The Arbitrator finds the doctor's final opinions of September 26, 2017 (RX 25) persuasive only to the extent that she agrees Petitioner had left shoulder complaints before the March 10, 2017 accident. The Arbitrator attributes these complaints to overuse, secondary to the restrictions relating to the right shoulder, and work conditioning. See further below. Dr. Giannoulias lost credibility, from the Arbitrator's perspective, when he opined, in his final report, that Petitioner requires no left shoulder restrictions despite needing a left rotator cuff repair. RX 25.

Arbitrator's Conclusions of Law in 14 WC 34638

Did Petitioner establish causal connection?

The Arbitrator finds that the undisputed accident of March 26, 2014 resulted in a right shoulder condition that required surgery and revision surgery. The Arbitrator further finds that Petitioner also established causation as to the need for a third surgery, i.e., a right biceps tenodesis, as recommended by Dr. Tonino. Petitioner declined to undergo this surgery, not unreasonably. The Arbitrator further finds that Petitioner established causation as to the need for the permanent restrictions that Dr. Tonino imposed following the valid functional capacity evaluation. Respondent's examiner agreed with the need for permanent restrictions. The Arbitrator assigns no weight to the evaluation-related opinions rendered by Rachel Viel. Viel criticized the evaluator for allegedly failing to use a "legitimate testing method" to determine validity. RX 16. The Arbitrator finds this criticism ironic, given that the evaluation was performed at a facility of Respondent's selection. The Arbitrator assigns some weight to

Diaz's testimony as to the demands of a Bobst operator job but notes the following: 1) Diaz took issue with some aspects of the job description; 2) Diaz conceded there are two types of Bobst machines, i.e., small and large; and 3) it is clear to the Arbitrator, based on Petitioner's credible testimony as to the mechanism of the March 26, 2014 accident, that in the event a plate "derailed," a Bobst operator would have to quickly deal with a weight ten times as heavy as 40 pounds. The job description is deficient in that it does not contemplate the type of situation Petitioner encountered on March 26, 2014.

In rendering the above causation-related opinions, the Arbitrator relies on Petitioner's credible testimony as to the mechanism of injury, Petitioner's credible denial of any prior right shoulder problems, the medical records and the causation-related opinions voiced by Dr. Tonino and Dr. Giannoulias.

The Arbitrator also finds that Petitioner established causation as to some left shoulder and neck complaints that first surfaced in 2015. The Arbitrator attributes these complaints to overuse resulting from the various restrictions Dr. Tonino imposed with respect to Petitioner's use of his dominant right arm. The Arbitrator recognizes that Dr. Giannoulias did not believe Petitioner's quality department tasks could have caused left-sided symptoms. Dr. Giannoulias based this opinion on job videos that Petitioner took issue with.

The Arbitrator further finds that the work conditioning Petitioner underwent in the fall of 2016 led to left arm and neck complaints that required treatment and imaging. In so finding, the Arbitrator relies on the work conditioning records and the notes of Laura Thometz, PA-C, Dorota Pietrowski and Dr. Tonino. Petitioner would not have required work conditioning but for his undisputed right shoulder injury. Respondent's examiner, Dr. Giannoulias, never opined that the work conditioning was unnecessary. Viel conceded it was reasonable for Petitioner to undergo work conditioning for two to four weeks.

Is Petitioner entitled to temporary total disability benefits?

In 14 WC 34638, Petitioner seeks three intervals of temporary total disability: September 29, 2014 through January 8, 2015, February 19, 2015 through March 10, 2016 and June 27, 2016 through December 19, 2016. Respondent disputed this claim at the hearing. Arb Exh 1. The parties agree Respondent paid certain temporary total disability benefits. Those payments are recorded in RX 9.

The Arbitrator notes that, with the exception of RX 19, an exhibit that covers only two one-week periods of employment, neither party offered into evidence any wage or employment records showing the dates Petitioner worked. Such records would have been very helpful. As it is, the Arbitrator is left with Petitioner's testimony, which was sometimes vague or conflicting as to the various dates he resumed working, and the medical records.

With respect to the first claimed interval, the Arbitrator finds Petitioner was temporarily totally disabled from December 2, 2014 (the date of the first right shoulder surgery) through January 8, 2015, a period of 5 3/7 weeks. Under cross-examination, Petitioner acknowledged that, after the March 26, 2014 accident, he continued working for Respondent until his surgery. Respondent is entitled to credit for the benefits it paid (at the rate of $739.87 per week) from December 2, 2014 through January 11, 2015. There was an overpayment during this period.

With respect to the second claimed interval, the Arbitrator finds Petitioner was temporarily totally disabled from February 19, 2015 through May 18, 2015 and again from July 20, 2015 (the date Dr. Tonino took Petitioner off work pending revision surgery) through February 7, 2016. Respondent contends that Petitioner could have performed restricted work after July 20, 2015 but, in the Arbitrator's view, Dr. Tonino had a valid basis for taking Petitioner off work as of that date, given his examination findings and suspicion of a recurrent labral tear. The Arbitrator declines to award benefits from May 19, 2015 through July 19, 2015, as requested by Petitioner, because Petitioner failed to prove he was off work during this period. There is no evidence Petitioner saw Dr. Tonino between April 27, 2015 and July 6, 2015. On July 6, 2015, Dr. Tonino noted that Petitioner had resumed working following a "second opinion," presumably referring to Dr. Giannoulias's re-examination of April 2015. Respondent paid temporary total disability benefits through May 18, 2015.

With respect to the third claimed interval, the Arbitrator finds Petitioner was temporarily totally disabled from June 27, 2016 (the date Dr. Tonino directed him to stay off work while undergoing work conditioning) through September 22, 2016 (the date Dr. Tonino released him to restricted duty). Respondent paid no temporary total disability benefits during this period. RX 9. The Arbitrator finds it reasonable for Dr. Tonino to have kept Petitioner off work while engaging in work conditioning. Dr. Giannoulias and Vial agreed with the need for work conditioning. Petitioner encountered two legitimate problems while attempting to pursue work conditioning: 1) he changed facilities due to ATI being closer to his house; and 2) he began experiencing left arm and neck problems after switching to ATI, which prompted Dr. Tonino to place the regimen on hold and order various consultations and tests.

Is Petitioner entitled to reasonable and necessary medical expenses?

In 14 WC 34638, Petitioner claims various unpaid medical bills. Arb Exh 1. PX 2(a). PX 8(a).

Petitioner offered into evidence a large collection of bills from Loyola University Medical Center. PX 2(a). These bills relate to treatment provided between September 8, 2014 and December 19, 2016. Many of the bills show $0 balances. Some, including bills for therapy and imaging performed in 2016, show balances. Respondent asserts Petitioner "is not entitled to any allegedly unpaid medical bills." Respondent offered into evidence a lengthy print-out of the medical payments it made in this case. RX 10. Petitioner raised no objection to RX 10. Petitioner's counsel made no effort to specify which of the many Loyola bills remain unpaid and Respondent's counsel made no effort to coordinate his client's payments with the claimed bills.

The Arbitrator has previously found that Petitioner established causation as to a right shoulder condition that required surgery and as to left shoulder and cervical spine complaints that required imaging and work-up. The Arbitrator further finds that the care underlying the bills in PX 2(a) was reasonable and necessary. In none of his many reports did Respondent's examiner opine that Petitioner's care was unreasonable or excessive.

The Arbitrator awards Petitioner the bills in PX 2(a), subject to the fee schedule and with Respondent receiving credit for the payments reflected in RX 10.

Petitioner also claims a $3,500.00 bill from Oak Brook X-ray and Imaging. This bill relates to the cervical spine MRI of November 8, 2016 (PX 8(a)). It does not appear on Respondent's payment print-out. As noted above, the Arbitrator has previously found that Petitioner established causation as to

cervical spine symptoms that warranted imaging and evaluation. The Arbitrator awards Petitioner the Oak Brook X-ray and Imaging bill in the amount of $3,500.00, subject to the fee schedule.

Is Petitioner entitled to prospective care?

Petitioner placed prospective care at issue in this case but, as of the hearing, the only pending treatment was left shoulder surgery recommended by Drs. Tonino and Giannoulias. See the Arbitrator's prospective care award in 17 WC 7694, below.

Is Respondent liable for penalties and fees?

In 14 WC 34638, Petitioner seeks penalties and fees on both temporary total disability benefits and medical expenses. With respect to the former, the Arbitrator notes that when Respondent paid Petitioner benefits, it paid them at the rate of $739.87 per week. RX 9. At the hearing, the parties stipulated to an average weekly wage of $1,083.56 in both cases. Arb Exh 1-2. This wage gives rise to a slightly lower temporary total disability rate of $722.37. The Arbitrator has considered this, along with the total payments reflected in RX 9 and RX 9(a), the underlying disputes and the uncertainty as to some of the dates Petitioner was off work, in evaluating Respondent's liability for penalties and fees. The Arbitrator again notes she was not provided with time cards or payroll records. While an employer bears the burden of showing it acted in an objectively reasonable manner in disputing the payment of temporary total disability benefits, once penalties and fees are placed at issue, the claimant has the initial burden of proving when he was off work due to his injury.

The Arbitrator finds that Respondent is liable for Section 19(l) penalties in the amount of $5,070.00 (169 days x $30/day) based on its late payment of temporary total disability benefits covering the post-operative period October 21, 2015 through December 20, 2015. Respondent did not issue these benefits until April 7, 2016. RX 9. There was a delay of 169 days between October 21, 2015 and April 7, 2016. Section 19(l) penalties are in the nature of a mandatory late fee. Oliver v. IWCC, 2015 IL App (1st) 143836WC.

The Arbitrator further finds that Respondent is liable for additional Section 19(l) penalties in the amount of $4,930.00 (the balance of the statutory $10,000 maximum) based on its failure to pay any temporary total disability benefits for the period June 27, 2016 through September 22, 2016 prior to the hearing of January 12, 2018.

The Arbitrator declines to award penalties and fees on the awarded medical bills because Petitioner offered no evidence of a "written demand for payment" of any of these bills, as required by Section 19(l). Petitioner's penalties/fees petition simply sets forth a generic demand for payment of medical expenses. PX 9.

Arbitrator's Conclusions of Law in 17 WC 7649

Did Petitioner sustain an accident on March 10, 2017 arising out of and in the course of his employment? Did Petitioner provide timely notice of said accident?

The Arbitrator, having considered Petitioner's credible and unrebutted testimony along with Dr. Tonino's note of March 13, 2017 and the Facebook photographs (RX 20) offered by Respondent, finds that Petitioner sustained an accident on March 10, 2017 arising out of and in the course of his

employment. Petitioner testified the accident occurred while he was on Respondent's premises, performing a work-related task (i.e., removing flaps from paper products). The two witnesses who testified for Respondent did not refute Petitioner's account of the accident.

The Arbitrator further finds that Petitioner provided timely notice of the accident. Petitioner credibly testified he notified three supervisors/managers of the accident the same day it occurred. He further testified that one of these individuals completed an accident report. That testimony is buttressed by Dr. Giannoulias's reference to a Form 45 "that did confirm an injury on March 10, 2017." RX 5. None of the three individuals Petitioner identified appeared at the hearing.

In finding accident and timely notice, the Arbitrator has considered the Facebook photographs offered by Respondent. These photographs show Petitioner at his surprise birthday party on the night of March 10, 2017. One shows Petitioner holding his one-year-old daughter but he is holding her on the right side of his body. It appears to the Arbitrator he is using his left hand/arm only for support. Petitioner testified the photograph was taken after he took a Vicodin that provided pain relief. He also testified he carried his daughter for only 10 to 15 seconds and did not lift anything else that night. The photograph does not undermine Petitioner's credible account of the accident.

Did Petitioner establish a causal connection between the March 10, 2017 accident and the need for the left shoulder surgery recommended by both Dr. Tonino and Respondent's examiner?

The Arbitrator finds that the accident of March 10, 2017 was a cause of Petitioner's current left shoulder condition of ill-being and contributed to the need for the left rotator cuff repair recommended by both Dr. Tonino and Dr. Giannoulias, Respondent's examiner. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony as to the mechanics of the accident; 2) Petitioner's credible testimony that he experienced a pop and a stinging sensation in his left shoulder after the accident; 3) the history that Dr. Tonino recorded on March 13, 2017; 4) the results of the December 2016 left shoulder MRI and April 2017 left shoulder MR arthrogram; and 5) Dr. Giannoulias's original opinion that the accident caused the full-thickness left rotator cuff tear demonstrated on the MR arthrogram. RX 5.

The Arbitrator recognizes that Petitioner experienced left shoulder symptoms at various times prior to March 10, 2017. The earliest mention of such symptoms was in February 2015. Left-sided symptoms are also documented in the 2016 work conditioning records. The Arbitrator also recognizes that Dr. Giannoulias did not link those symptoms to Petitioner's quality department job activities when he re-examined Petitioner in October 2016. The Arbitrator notes Dr. Giannoulias based this opinion, at least in part, on job videos which Petitioner described as inaccurate, in terms of the specific tasks he performed and the materials he used.

In short, the Arbitrator views Petitioner's current left shoulder condition as multi-factorial, with pre-accident work duties, work conditioning and the March 10, 2017 accident contributing to the condition. In Illinois, it has long been held that an accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003).

Is Petitioner entitled to temporary total disability benefits?

In 17 WC 7694, Petitioner claims he was temporarily totally disabled from March 13, 2017 through the hearing of January 12, 2018. Respondent disputes this claim based on its accident and causation defenses. The Arbitrator has previously found that Petitioner established accident and causation. There is no dispute that Petitioner has a left rotator cuff tear and requires surgery. In his report of July 28, 2017, Respondent's examiner, Dr. Giannoulias agreed with Dr. Tonino's surgical recommendation but found Petitioner capable of very light duty with no lifting, pushing or pulling over 5 pounds and no overhead work using the left shoulder. RX 5. In his supplemental report, issued the same day, he indicated his opinions remained unchanged after reviewing surveillance videos from April 2017 (RX 12) and the March 10, 2017 Facebook photograph. RX 5. In his final report, issued September 26, 2017, he again found Petitioner to be a surgical candidate. The Arbitrator views Petitioner's causally related left shoulder condition as unstable. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). The Arbitrator finds it reasonable for Dr. Tonino to have kept Petitioner off work since March 13, 2017, in light of the previous significant right shoulder problems, the permanent restrictions relative to the right shoulder and the need for left shoulder surgery. The Arbitrator gives no weight to Dr. Giannoulias's opinion that Petitioner requires no restrictions relative to his left shoulder even though he needs a left rotator cuff repair.

Is Petitioner entitled to reasonable and necessary medical expenses?

On the Request for Hearing form in 17 WC 7694 (Arb Exh 2), Petitioner indicated he was claiming bills in PX 2(a) [Loyola] and PX 8(a) [Oak Brook X-ray and Imaging]. These bills do not include charges for treatment rendered after the March 10, 2017 accident. The Arbitrator has previously awarded the bills in 14 WC 34638 [see above].

Is Petitioner entitled to prospective care?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Drs. Tonino and Giannoulias agree that Petitioner has a left rotator cuff tear and requires surgery. The Arbitrator awards prospective care in the form of left shoulder surgery.

Is Respondent liable for penalties and fees?

The Arbitrator declines to award penalties and fees in 17 WC 7694. The Arbitrator does not view Respondent's accident and causation defenses as objectively unreasonable under all of the existing circumstances. Petitioner was working alone at the time of the March 10, 2017 accident, by his own admission. Moreover, Respondent had some basis, i.e., Quiroz and the "flaps" video/image, for questioning whether the task Petitioner was performing at the time of the accident could have given rise to the injury. The Arbitrator accepts Petitioner's account (i.e., that the video is inaccurate in that he was working with heavy, "E-Flu" paper and hurrying to meet a customer's demands) but is unable to find that Respondent acted vexatiously in relying on Quiroz and the video.

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

Jamie Cahue,

Petitioner,

vs. NO: 17 WC07694

Menasha Packing,

Respondent.

18IWCC0552

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 13, 2018, 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.

18IWCC0552

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 $65,000.00. 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.

SEP 7 - 2018

DATED:
o083018
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

CAHUE, JAIME
Employee/Petitioner

Case# **14WC034638**

17WC007694

MENASHA PACKAGING
Employer/Respondent

18IWCC0552

On 2/13/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% 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:

0815 ACEVES & PEREZ
EMILIANO PEREZ JR
1931 N MILWAUKEE AVE
CHICAGO, IL 60647

0734 HEYL ROYSTER VOELKER & ALLEN
BRAD A ANTONACCI
120 W STATE ST PO BOX 1288
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)

Jaime Cahue
Employee/Petitioner

v.

Menasha Packaging
Employer/Respondent

Case # **14** WC **34638**

Consolidated cases: **17 WC 7694**

18IWCC0552

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 **01/12/18**. 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 _____

18IWCC0552

FINDINGS

On the date of accident, **03/26/2014**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds a causal connection between Petitioner's undisputed accident of March 26, 2014 and his current post-operative right shoulder condition of ill-being. The Arbitrator also finds that Petitioner established causation as to the need for the permanent restrictions imposed by Dr. Tonino. The Arbitrator further finds that Petitioner established causation as to left arm and cervical spine symptoms that warranted imaging and evaluation.

In the year preceding the injury, Petitioner earned **$56,345.12**; the average weekly wage was **$1,083.56**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **4** dependent children.

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

The parties agree Respondent paid Petitioner $28,090.71 in benefits, including a $5,326.88 permanency advance, prior to the hearing of January 12, 2018. Arb Exh 1. RX 9 and 9(a).

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $722.37/week during the following four intervals: December 2, 2014 through January 8, 2015; February 19, 2015 through May 18, 2015; July 20, 2015 through February 7, 2016; and June 27, 2016 through September 22, 2016. Respondent is entitled to credit for the temporary total disability benefits it paid prior to the hearing, per the parties' agreement. Arb Exh 1.

Respondent shall pay the reasonable and necessary medical expenses of Loyola University Medical Center/Dr. Tonino in PX 2(a), subject to the fee schedule and with Respondent receiving credit for the payments it has made per RX 10. Respondent shall pay the $3,500.00 bill of Oak Brook X-ray and Imaging in PX 8(a), subject to the fee schedule.

For the reasons set forth in the attached decision, the Arbitrator finds that Respondent is liable for Section 19(l) penalties in the maximum statutory amount of $10,000.00.

The Arbitrator addresses prospective care in the decision in 17 WC 7694.

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.

18IWCC0552

Molly C Mason

Signature of Arbitrator

2/9/18
Date

ICArbDec19(b)

FEB 13 2018

Jaime Cahue v. Menasha Packaging
14 WC 34638 and 17 WC 7649 (consolidated)

18IWCC0552

Summary of Disputed Issues in Both Cases

In 14 WC 34638, the parties agree Petitioner sustained an accident while working as a machine operator for Respondent on March 26, 2014. Petitioner underwent two right shoulder surgeries, in 2014 and 2015, following this accident. He declined to undergo a third surgery (a biceps tenodesis) recommended by Dr. Tonino. The doctor released him to work, subject to several permanent restrictions, on December 19, 2016, following a valid functional capacity evaluation performed at a facility of Respondent's selection.

Petitioner asserts that, at various points during his right shoulder treatment, Respondent gave him tasks that were outside the restrictions imposed by Dr. Tonino. He further asserts he overused his non-dominant left arm while performing those tasks. Respondent disputes these assertions. Petitioner further claims he injured his left shoulder at work on March 10, 2017. This injury is the subject of the second claim, 17 WC 7649.

In 14 WC 34638, the disputed issues include causal connection, medical expenses, temporary total disability during three intervals, penalties/fees, prospective care and underpayment of temporary total disability benefits. In 17 WC 7649, the disputed issues include accident, notice, medical expenses, temporary total disability, penalties/fees and prospective care in the form of left shoulder surgery.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner, age 37, testified he began working as a machine operator for Respondent three years before his undisputed accident of March 26, 2014. Respondent produces customized paper and corrugated products. T. 17-18.

Petitioner testified his job involved operating one half of a machine that was 15 feet long. He had to insert metrics plates and cutting dies in the machine during set-ups to produce products of specific dimensions. A metrics plate is 59 x 42 inches in size and weighs about 450 pounds. T. 19. He also had to use tools, including wrenches and screwdrivers, to set paper size. T. 18-20.

Petitioner testified that, prior to his accident of March 26, 2014, he removed a 450-pound metrics plate from his machine so that he could remove debris from the machine and clean the plate in preparation for the next job. The plate moves along a track that has wheels on both sides. As he attempted to push the plate back into the machine, it fell off the track on the right. At that point, his left hand was on top of the plate and his right hand was underneath it. As the plate tipped, it began to tug his right arm down. T. 21-22. His helper, who was three feet away, and a supervisor came over and attempted to hold the plate up so that Petitioner could extricate his right hand. After Petitioner freed his hand, the plate fell to the floor. Petitioner testified it took a forklift to lift the plate back up. T. 21-25.

Petitioner testified he felt a pop and stinging in his right shoulder when the plate fell to the side. T. 24-25. He immediately reported the injury to Tony, a supervisor. Tony took photographs and escorted Petitioner to an office. Tony then telephoned Dan, an individual Petitioner described as a "therapy guy from Wisconsin" who came to Respondent's facility twice weekly to assess workers. T. 26.

Per instructions received from Dan, Tony told Petitioner to apply ice and Icy Hot to his shoulder and take Tylenol. T. 27-28. Petitioner testified he reported to work during the two weeks following the accident but did not actually perform any tasks. He merely sat in an office, applying ice to his shoulder and taking Advil for pain. T. 29.

Petitioner testified he first sought formal care on April 7, 2014, when he saw Dr. Rodriguez, his primary care physician. Dr. Rodriguez recorded a history of the work accident and noted a complaint of 6/10 right shoulder pain. After performing an examination, he prescribed a right shoulder MRI, with and without contrast, along with a Medrol Dosepak and Norco. PX 1, pp. 3-5. He released Petitioner to work. PX 1, p. 1. T. 29-30.

The MRI, performed without contrast on May 6, 2014, showed no significant effusion, mildly tendonopathic supraspinatus and infraspinatus tendons, without evidence of tearing, and minimal low grade chondromalacia along the anterior margin of the glenoid. PX 1, p. 18.

Petitioner returned to Dr. Rodriguez on May 16, 2014. The doctor again noted a complaint of right shoulder pain. Petitioner testified the doctor recommended he see a specialist. T. 30-31.

Petitioner testified that, during this time period, he was performing various light duty tasks, including sweeping, for Respondent. T. 31.

Petitioner returned to Dr. Rodriguez on August 4, 2014, with the doctor noting a complaint of 5/10 right shoulder pain. On right shoulder examination, the doctor noted a decreased range of motion, tenderness and spasm. PX 1, p. 23. He recommended an orthopedic referral and released Petitioner "to work on a 12-hour shift." PX 1, p. 30.

Petitioner saw Dr. Tonino, an orthopedic surgeon, on September 8, 2014. T. 31. Petitioner initially testified he referred himself to Dr. Tonino. He went on to state that the referral actually came from Dr. Rodriguez. He told Dr. Rodriguez he wanted to see someone at Loyola, which was close to his home, with the doctor suggesting Dr. Tonino. T. 31-32.

Dr. Tonino documented the work accident in his note of September 8, 2014. He noted that a 400-pound plate "yanked [the] right shoulder down." PX 2, p. 11. He described the May 6, 2014 MRI images as "degraded" due to motion. After examining Petitioner and obtaining X-rays, he tentatively diagnosed a labral tear, based on Petitioner's complaints and the mechanism of injury. He prescribed an MR arthrogram. He allowed Petitioner to continue normal work, indicating Petitioner "seems to be doing pretty well with that." PX 2, pp. 4-6.

On September 29, 2014, Dr. Tonino noted ongoing right shoulder complaints. He interpreted the MR arthrogram as showing a tear at the base of the anterior/inferior segment of the glenoid labrum. He recommended arthroscopic surgery. PX 2, p. 20. Petitioner testified that Dr. Tonino took him off work (T. 33) but the doctor's note reflects he released Petitioner to full duty. PX 2, p. 25.

Petitioner returned to Dr. Tonino on November 3, 2014. The doctor noted a complaint of numbness and tingling extending up to the cervical spine and numbness going down the arm to the hand. After noting that Petitioner was scheduled to undergo right shoulder surgery on December 2nd, he referred Petitioner to "Dorothy" for a cervical spine work-up. T. 34. He released Petitioner to light duty with no lifting over 20 pounds. PX 2, pp. 28, 32.

Petitioner saw Dorota Pietrowski, an advanced practice nurse affiliated with Dr. Tonino, on November 4, 2014. Pietrowski documented a history of the work accident. She described Petitioner's symptoms as 50% right shoulder/arm and 50% neck. She indicated Petitioner denied left-sided symptoms. She recommended a cervical spine MRI. She noted that Petitioner "remains off of work" but released him to work. PX 2, pp. 37-39.

The cervical spine MRI, performed without contrast on November 4, 2014, showed mild multi-level degenerative changes without significant central canal or foraminal stenosis. PX 2, pp. 41-42.

On November 19, 2014, Pietrowski reviewed the cervical spine MRI results with Petitioner and suggested he undergo cervical spine therapy after the upcoming right shoulder surgery. She imposed no restrictions relative to the cervical spine. PX 2, pp. 45, 50.

Petitioner testified he did not undergo any cervical spine care at that time. T. 35.

Dr. Tonino operated on Petitioner's right shoulder on December 2, 2014, at Loyola. T. 35. In his operative report, he documented a partial tear of the rotator cuff and a "very complex superior labral tear." He described the biceps tendon as normal. PX 2, pp. 56-57.

On December 8, 2014, Respondent's carrier issued a check in the amount of $739.87 representing temporary total disability benefits from December 2, 2014 (the date of surgery) through December 8, 2014. The carrier continued issuing weekly checks thereafter through January 11, 2015. RX 9.

On January 8, 2015, Dr. Tonino prescribed therapy and released Petitioner to work with no use of the right arm. PX 2, p. 289.

Petitioner testified he began undergoing therapy at Industrial Rehab Allies, a facility selected by workers' compensation. T. 36.

Petitioner further testified that Respondent did not respect Dr. Tonino's restriction that he avoid using his right arm. Instead, Respondent assigned him to dust down pipes and sweep the entire facility, including stacks of skids, using a 3-foot industrial broom. T. 36-37.

Petitioner continued to see Dr. Tonino postoperatively. On February 19, 2015, the doctor noted ongoing right shoulder complaints along with some left shoulder symptoms. He noted the following:

> "With respect to work, apparently they are making him do pretty heavy work with one hand. I am afraid he is going to hurt his other shoulder."

Dr. Tonino administered a right subacromial injection. He directed Petitioner to increase his therapy visits from two to three times per week. He took Petitioner off work "until they can provide more reasonable one-handed work for him." PX 2, p. 313. T. 38.

Respondent's carrier issued weekly checks, each in the amount of $739.87, from February 19, 2015 through March 11, 2015. RX 9.

On March 18, 2015, Respondent's carrier issued a check in the amount of $739.87, representing weekly benefits from March 12 through March 18, 2015, but put a "stop" on this check the same day. RX 9.

On March 19, 2015, Dr. Toninio noted that Petitioner reported minimal improvement from the subacromial injection. He administered an intra-articular injection and directed Petitioner to continue therapy three times per week. He directed Petitioner to remain off work, again noting a lack of reasonable work using one arm. PX 2, p. 328.

Petitioner testified that neither injection provided relief. T. 38-39.

At Respondent's request, Dr. Giannoulias, an orthopedic surgeon, examined Petitioner on April 21, 2015. The doctor's report (RX 1) sets forth a consistent history of the work accident and subsequent labral repair. The doctor noted a history of a left hand fracture.

On right shoulder examination, the doctor noted well-healed arthroscopic incisions, a substantial amount of pain over the acromioclavicular joint with palpation anteriorly and superiorly, pain with cross-arm adduction, popping with elevation past 140 degrees, limited rotation and no pain over the biceps tendon.

The doctor indicated he reviewed a job description and Form 45 in addition to numerous medical records.

The doctor found a causal relationship between the work accident and the labral tear. He further found that Petitioner likely had pre-existing acromioclavicular joint degeneration that was aggravated by the accident. He characterized the treatment to date as reasonable and necessary. He recommended an acromioclavicular injection. While he acknowledged some stiffness of the shoulder, he did not view Petitioner as having a "true frozen shoulder." He believed the stiffness would resolve with four more weeks of therapy. He projected that Petitioner would reach maximum medical improvement within a month or two. He found Petitioner capable of working so long as he avoided all overhead work and any lifting, pushing or pulling over 10 pounds. He did not find Petitioner capable of resuming his machine operator duties. He found no evidence of symptom magnification. RX 1.

On April 21, 2015, Respondent's carrier issued a check in the amount of $739.89 paying Petitioner, retroactively, from March 12 through March 18, 2015. RX 9.

On April 27, 2015, Dr. Tonino noted that Petitioner experienced only transient improvement following the intra-articular injection. He viewed Petitioner as having "some early adhesive capsulitis and possibly some internal derangement." He prescribed an MR arthrogram and kept Petitioner off work. PX 2, pp. 333-334. T. 39-40.

On May 6, 2015, Respondent's carrier issued a check in the amount of $739.87 representing temporary total disability benefits from April 30, 2015 through May 6, 2015. RX 9.

On June 26, 2015, Respondent's carrier issued a check in the amount of $1,268.35 representing temporary total disability benefits from May 7 through May 18, 2015. Respondent did not resume the payment of benefits until mid-September 2015. RX 9.

Petitioner returned to Dr. Tonino on July 6, 2015. T. 40. On re-examination, the doctor noted elevation to 120 degrees on the right, versus 160 on the left, and external rotation to 45 degrees on the right, versus 60 on the left. He noted a delay in obtaining approval for the previously prescribed MR arthrogram. He also noted that Petitioner had experienced an exacerbation since resuming work following a "second opinion." [He did not indicate exactly when Petitioner resumed working]. He recommended that Petitioner perform home exercises pending the MR arthrogram. PX 2, p. 350.

On July 20, 2015, Dr. Tonino interpreted the MR arthrogram as showing a possible recurrent labral tear versus post-operative changes. He recommended revision surgery, noting that Petitioner had "failed conservative treatment." He took Petitioner off work pending the surgery, noting: "we tried sending him back with restrictions but the employer does not accommodate and respect restrictions." PX 2, p. 358. PX 9, Exhibit 3. T. 40-41.

Respondent's examiner, Dr. Giannoulias, issued a supplemental report on August 5, 2015, after reviewing the MR arthrogram and Dr. Tonino's recent records. He interpreted the MR arthrogram as showing that the labrum "has not healed." He again attributed the labral injury to the work accident. Based on Petitioner's current symptoms of numbness and instability, he found a revision arthroscopy and Bankart repair to be appropriate. He anticipated that Petitioner would reach maximum medical improvement six months following this surgery. He recommended that Petitioner be restricted to "light sedentary" work with no lifting over 10 pounds and no overhead activity. RX 2.

On September 15, 2015, Respondent's counsel sent Petitioner's counsel a letter enclosing his appearance and a motion to dismiss. Respondent's counsel indicated it was his understanding that the payment of temporary total disability benefits would resume as of the following day, assuming Petitioner proceeded with the scheduled surgery. PX 9, Exhibit 4.

Dr. Tonino operated again on September 16, 2015, performing a revision labral repair and capsulorrhaphy of the right shoulder. In his operative report, he indicated that it appeared as if Petitioner "had a persistent labral tear which had not healed." He removed two slightly loose sutures and repaired the tear with a revision procedure using four sutures anteriorly to posteriorly. He described the rotator cuff as intact and the biceps tendon as normal. PX 2, pp. 372-373. T. 41.

On September 22, 2015, Respondent's carrier issued a check in the amount of $739.87 representing temporary total disability benefits from September 16 through September 22, 2015. Respondent continued the payment of benefits each week thereafter through October 20, 2015, at which point there was a gap until April 2016. RX 9.

On October 1, 2015, Dr. Tonino noted some complaints of right arm pain. He directed Petitioner to keep his arm in a sling for two weeks and then start therapy twice weekly. He also directed Petitioner to remain off work. He indicated he anticipated keeping Petitioner off work "for a significant time due to a history of the employer not following restrictions on his return to work last time." PX 2, p. 464. PX 9, Exhibit 6.

On October 7, 2015, Respondent's counsel sent Petitioner's counsel an E-mail stating: "we have nothing from you to support your request for any current benefits. Please send if you have anything." PX 9, Exhibit 8.

On October 12, 2015, Respondent's counsel sent Petitioner's counsel another E-mail, stating:

> "Because you are disallowing nurse case management, we need your express authority to contact the treating physician to discuss the modified work duties that we have available.
>
> If we do not receive your express authority by Wednesday, October 7, 2015, TTD benefits will be suspended on Monday, October 19, 2015."

PX 9, Exhibit 7. RX 22.

Petitioner testified he did not begin therapy as directed due to lack of approval. Workers' compensation wanted him to have therapy at Industrial Rehab Allies in Schaumburg but he wanted to go to ATI, which was closer to his home. T. 42.

On November 12, 2015, Dr. Tonino described Petitioner as doing "pretty well" but noted he had not yet started therapy due to "some sort of misunderstanding." He directed Petitioner to remain off work, begin therapy twice weekly and return in six to eight weeks, at which point he planned to address "updated work restrictions." PX 2, p. 474. PX 9, Exhibit 8.

On November 16, 2015, Petitioner's counsel sent "the most recent disability note" (presumably Dr. Tonino's note of the previous day) to Respondent's counsel via E-mail. Respondent's counsel sent the following response later the same day: " . . . look forward to litigating this one with you. He could be working but for your obstructions to modified duty." PX 9, p. 18.

On November 17, 2015, Respondent's counsel sent Petitioner's counsel a letter, via facsimile, advising him that Respondent "has one-handed work available" from 7 AM to 3 PM, Monday through Friday, at Petitioner's "normal hourly rate." Respondent's counsel asked for confirmation that Petitioner would resume working as of November 19th. RX 6. The following day, Respondent's counsel faxed another letter to Petitioner's counsel, acknowledging receipt of Dr. Tonino's restrictions and asking counsel to "advise Dr. Tonino that one-handed work is available," beginning November 19th. RX 6, 23.

Petitioner underwent an initial physical therapy evaluation at Loyola on November 30, 2015. On December 4, 2015, the therapist noted a complaint of "throbbing pain in the anterior shoulder today at rest." He also noted that Petitioner was using an ice pack at home. At the next session, on December 7, 2015, he noted that Petitioner reported moderate pain with elevation of the right shoulder. PX 2, p. 499. At the next two sessions, he noted that Petitioner reported "popping" and sharp pain in the shoulder with elevation. PX 2, p. 501.

On December 30, 2015, Respondent's counsel faxed another letter to Petitioner's counsel, indicating that Petitioner's 19(b) petition was "dismissed" on December 17th. He reiterated the offer of one-handed duty and asked why Petitioner required rescheduling of a Section 12 re-examination from December 22, 2015. RX 6.

At Respondent's request, Dr. Giannoulias re-examined Petitioner on January 5, 2016. In his report, the doctor noted that Petitioner was still complaining of right arm pain and numbness, despite

the recent revision surgery. On re-examination, he noted some supraspinatus atrophy, elevation to about 150 degrees, external rotation to about 50 degrees and some pain with abduction and external rotation. The doctor reiterated his causation finding and recommended four more weeks of therapy. He anticipated that Petitioner would reach maximum medical improvement six to eight months after the revision surgery. He found Petitioner capable of full-time light duty with temporary restrictions of no lifting, pushing or pulling over 10 pounds. He indicated that permanent restrictions were "dependent upon course of healing and response to further therapy." While he described Petitioner as magnifying some of his symptoms with end range of motion, he did not find this inappropriate "for having started physical therapy only six weeks ago." RX 3.

Petitioner returned to Dr. Tonino on January 21, 2016 (T. 42-43), with the doctor noting the therapist's observations. The doctor indicated that external rotation was still limited to 30 degrees but that Petitioner otherwise appeared to be doing well. He also indicated that Petitioner "has had no injuries after surgery." He directed Petitioner to remain off work and continue therapy. PX 2, pp. 508-509.

On January 26, 2016, Respondent's counsel forwarded Dr. Giannoulias' January 18, 2016 report to Petitioner's counsel via facsimile and indicated that Respondent could accommodate the restrictions recommended by Dr. Giannoulias. Counsel also indicated that one-handed work was "still available," referencing prior offers of such work on November 17 and 18, 2015 and December 30, 2015. RX 6.

On January 29, 2016, Amanda Faust, Respondent's human resources manager, wrote to Petitioner indicating that Respondent had work available within the restrictions recommended by Dr. Giannoulias and directing Petitioner to report to work on February 8, 2016. Faust informed Petitioner that, if he failed to report on said date, Respondent would begin counting his absences as occurrences against its attendance policy. RX 7. Respondent's counsel forwarded a copy of Faust's letter to Petitioner's counsel the same day and asked for permission to contact Dr. Tonino for the sole purpose of asking him whether Petitioner could perform modified or one-handed work. RX 8.

Under cross-examination, Petitioner testified he returned to work in February 2016. T. 83.

On March 10, 2016, Dr. Tonino that Petitioner was still experiencing popping in the shoulder when lifting. He again noted limited external rotation. He indicated Petitioner "will continue with work restrictions for his right arm." He directed Petitioner to continue therapy. PX 2, p. 511.

Petitioner acknowledged asking Dr. Tonino to release him to full duty on March 10, 2016. He made this request because he was not receiving benefits. T. 43. He did not, however, actually resume full duty. Respondent "had [him] showing another operator how to operate the machine." T. 46.

Petitioner saw Laura Thometz, PA-C, at Loyola on April 1, 2016. Thometz noted that Petitioner was performing light duty and complained of increased right shoulder pain with lifting as well as numbness and tingling in the entire right arm during the preceding three weeks. She also noted that Petitioner denied neck pain or any acute injury to the shoulder. On examination, she noted tenderness over the right acromioclavicular joint and right anterior shoulder and pain with Jobe's and O'Brien's testing. She directed Petitioner to continue his home exercises and see Dr. Tonino. She continued the previous restriction of no right arm usage. PX 2, p. 516.

Petitioner saw Dr. Tonino on April 4, 2016, and complained of popping in the right shoulder and difficulty elevating beyond 120 degrees. The doctor also noted that Petitioner complained of numbness and tingling in the right arm with right-sided lateral neck pain. He released Petitioner to work with no lifting over 10 pounds and no overhead or repetitive usage of the right arm. PX 2, p. 517. T. 44.

Petitioner testified that, after he presented the April 4, 2016 restrictions to Respondent, he was assigned to the task of removing a 2-inch layer of glue from a piece of steel pipe that was 9 feet long. He had done this job in the past and knew it required the use of both hands. He told human resources he could not perform this job. Respondent assigned other work to him. T. 46-47.

On April 7, 2016, Respondent issued a check in the amount of $5,324.04 representing disputed temporary total disability benefits from October 21, 2015 through December 20, 2015. RX 9.

At the next visit, on April 21, 2016, Dr. Tonino noted persistent complaints. He recommended another MR arthrogram and released Petitioner to work with no right arm usage. PX 2, p. 518. T. 48.

Petitioner testified that Respondent then assigned him to "unstacking and restacking skids." This involved sorting through and moving stacks of misprinted boxes and bundles of "E-Flu" paper. Petitioner described the "E-Flu" paper as a "top of the line," heavy paper. He testified that 25 sheets of this paper can weigh up to 30 pounds, "including the glue." Each "E-Flu" bundle contained 25 sheets. He had to transfer the boxes and "E-Flu" bundles from skids to a table and from the table to skids. The table was about 3 feet high. He used only his left hand and arm to move the bundles, cut the string around each bundle and sort through the boxes and paper. T. 49-50. This job lasted three months. He finished three to five skids per day, with each skid containing 24 to 25 bundles. T. 50.

The repeat right shoulder MR arthrogram, performed on May 10, 2016, showed contrast insinuation into the inferior labrum, "consistent with a tear," as well as tendinosis of the intra-articular biceps tendon, extension of contrast between the infraspinatus and supraspinatus tendons and mild acromioclavicular joint osteoarthritis. PX 2, pp. 512-513. T. 51.

On May 16, 2016, Dr. Tonino interpreted the MR arthrogram as likely showing post-operative changes rather than anything new. He noted that most of Petitioner's pain was "anteriorly near the biceps tendon." He prescribed additional therapy along with a Medrol Dosepak. He continued the previous restriction of no right arm usage. PX 2, p. 519.

On June 27, 2016, Dr. Tonino noted complaints of pain in both shoulders. He noted that, while Petitioner had been directed to avoid using his right arm, he was "doing work with both arms . . . but using primarily his left shoulder." On examination, he noted tenderness over the bicipital groove bilaterally, elevation to 120 degrees bilaterally and normal rotator cuff strength bilaterally. He took Petitioner off work pending a functional capacity evaluation. PX 2, pp. 520-521. Petitioner testified that Dr. Tonino prescribed this evaluation after he declined to undergo a third right shoulder surgery. T. 51.

Petitioner underwent a functional capacity evaluation at Industrial Rehab Allies on July 8, 2016. Petitioner testified that Respondent's carrier set up this evaluation. T. 52. The evaluator, Steve Adamkiewicz, M.S. [hereafter "Adamkiewicz"], rated the evaluation as valid. He found that Petitioner "demonstrated work tolerance at the light-medium physical demand level" and that his BOBST operator job was rated at a medium physical demand level. He referenced both Petitioner's description of his job duties and a job analysis provided by Triune Health Group rating the BOBST job at the medium physical

demand level "due to the occasional need to lift a 35-40 lb. cutting die and frequent feeding of handfuls of sheets into the hopper weighing 25 to 30 pounds." PX 6, p. 7. He suggested that Petitioner undergo work conditioning to increase his tolerance. He noted that Petitioner reported "experiencing left shoulder pain since working light duty" and complained of constant right proximal biceps pain. PX 6. At the hearing, Respondent offered into evidence a report from Rachel K. Viel, MS, PT [hereafter "Viel"] dated October 11, 2016, in which Viel concluded she could not determine whether the functional capacity evaluation results were truly valid, "due to the limitations of validity testing." RX 16.

On August 4, 2016, Dr. Tonino noted the results of the functional capacity evaluation. He also noted that Petitioner was still experiencing left shoulder pain. He recommended work conditioning. He directed Petitioner to remain off work and return in six weeks. T. 52. PX 2, p. 522. T. 52. In her report of October 11, 2016, Viel concluded that it was reasonable for Petitioner to undergo work conditioning for two to four weeks, with the goal of improving his frequent material handling tolerances. RX 16.

Based on records and correspondence in PX 6, it appears Petitioner began attending work conditioning at Industrial Rehab Allies in Lombard on August 16, 2016 but began cancelling sessions as of August 22nd "because he did not have any gas money." Adamklewicz wrote to Dr. Tonino on September 16, 2016, indicating that, with the encouragement of the workers' compensation carrier, Petitioner had started attending sessions at a different facility closer to home but began experiencing left upper extremity shooting pains after two sessions. Adamklewicz advised Dr. Tonino that Petitioner was scheduled to undergo a spinal evaluation. Adamklewicz also noted, correctly, that Petitioner had not received any workers' compensation benefits "for months."

Records in PX 7 reflect Petitioner began a course of work conditioning at ATI Physical Therapy on August 29, 2016. On September 6, 2016, Christopher Sullivan, ATC, reported to Dr. Tonino that Petitioner began the program at a light physical demand level and was "starting to feel increased pain in his other [i.e., left] shoulder with activity." Sullivan also noted that Petitioner's machine operator job was considered a medium physical demand level job, with occasional lifting of 50 pounds, based on the Dictionary of Occupational Titles.

On September 9, 2016, Petitioner saw Laura Thometz, PA-C, Dr. Tonino's assistant. T. 53. Thometz noted that Petitioner had started work conditioning at "RARA" but had switched to ATI, which was closer to him. She indicated this was "progressing well until yesterday," at which point Petitioner "woke up with his entire left arm . . . cold and numb." She noted that Petitioner felt he "may have overdone it in work conditioning." On left upper extremity examination, she noted pain with impingement maneuvers and rotator cuff testing. She directed Petitioner to hold off with work conditioning until he could be evaluated by a spine specialist. PX 2, pp. 523-524.

On September 12, 2016, Sullivan reported that Petitioner reported having increased pain with "lift and carry" exercises and was complaining of increased numbness in his left forearm and "the same pain in his right arm." PX 7, pp. 1-2.

On September 14, 2016, Petitioner returned to Dorota Pietrowski, RN, MSN, at Loyola. She noted that Petitioner reported developing radiating left arm symptoms on September 7th. She also noted that Petitioner had been undergoing work conditioning but denied any specific accident or injury. On examination, she noted numbness in the left forearm. She diagnosed cervicalgia with possible left arm radiculopathy. After reviewing the 2014 cervical spine MRI, and noting that Petitioner's symptoms were right-sided at that time, she recommended a new cervical spine MRI. PX 2, p. 525.

On September 22, 2016, Dr. Tonino noted that Petitioner developed left arm symptoms while participating in work conditioning and was still experiencing right shoulder symptoms. He also noted the cervical spine MRI recommendation. He released Petitioner to work with no lifting over 10 pounds and no overhead or repetitive use of the right arm. PX 2, p. 532.

At Respondent's request, Dr. Giannoulias examined Petitioner a third time on October 18, 2016. In his report, he noted ongoing right shoulder and arm symptoms. On right shoulder re-examination, he noted no pain to palpation of the acromioclavicular joint, no crepitation, elevation to about 160 degrees, external rotation to 40 degrees, internal rotation to the upper buttock, 4+/5 strength, no instability and pain with end range of motion. He noted no abnormalities on left shoulder examination.

Dr. Giannoulias indicated he reviewed additional records from Dr. Tonino, the functional capacity evaluation report, a description of a BOBST operator job and a video "of the quality position [Petitioner] more recently was working in." He found the activities in the video "not consistent with causing an overuse injury of the upper extremities." With respect to the right shoulder, he diagnosed post-operative capsulitis from the labral repair and a healed labral tear. He did not diagnose any left shoulder condition, based on his negative examination. He did not link Petitioner's left shoulder complaints to either the work accident or the duties shown on the video. He related only the right shoulder treatment to the accident but characterized all of the treatment as reasonable and necessary. He did not believe Petitioner required more care for either shoulder. He described Petitioner's prognosis as fair. He recommended that Petitioner resume full-time work subject to the permanent light to medium restrictions established by the functional capacity evaluation. Based on the video, he believed Petitioner could perform work duties in Respondent's quality division. He did not believe Petitioner could resume his original machine operator job. RX 4.

On October 24, 2016, Dr. Tonino noted complaints of left-sided neck pain radiating to the left shoulder, right shoulder pain and right arm numbness. He noted no gross neurological abnormalities on examination. He indicated Petitioner still needed to see a cervical spine specialist. He continued the previous restrictions. PX 2, p. 533.

The cervical spine MRI, performed without contrast on November 8, 2016, showed mild spondylitic changes "without gross disc protrusion, spinal stenosis or foraminal stenosis at any cervical level." PX 8, pp. 1-2.

On November 28, 2016, Dr. Tonino noted that Petitioner had undergone the cervical spine MRI but had not yet seen a cervical spine specialist. After noting persistent cervical spine complaints, he again recommended a cervical spine consultation. PX 2, p. 535.

Petitioner testified he underwent a left shoulder MRI at Dr. Tonino's recommendation on December 9, 2016. T. 54.

On December 19, 2016, Dr. Tonino noted ongoing bilateral shoulder complaints. He recommended only conservative care for the left shoulder, based on the MRI and degree of symptoms. He found Petitioner to be at maximum medical improvement with respect to his right shoulder. He imposed permanent restrictions of no lifting over 10 pounds and no overhead or repetitive use of the right arm. PX 2, p. 536. T. 54-55.

Petitioner testified he presented the permanent restrictions to Respondent after December 19, 2016. He further testified Respondent did not honor these restrictions. He was assigned to the task of putting various tubes into designated slots that were overhead. The tubes were made of paper. They were 6 to 8 feet long. Each weighed "maybe two to three pounds tops." T. 56. Petitioner testified he had to use an 8-foot ladder to access the slots. He had to move the ladder back and forth all day long to get to the correct slots. T. 56-57. He also had to stack and restack skids, as he had done in the past. T. 57.

Petitioner testified he returned to Dr. Tonino on January 30, 2017. The doctor administered a right shoulder injection and modified his restrictions to no lifting over 5 pounds and no repetitive or overhead use of the right arm. T. 58.

Petitioner testified that Respondent did not honor Dr. Tonino's modified restrictions. Respondent again assigned him to stacking and restacking skids. T. 59.

Petitioner testified that, prior to his claimed accident of March 10, 2017, he was assigned to the task of breaking down flaps of "E-flu" paper. He testified he had to work under time pressure because the customer needed the paper as soon as possible. He had "eight units" of skids to work on, with each skid holding up to 7200 pieces. T. 59. For three days, he worked alone at a table that was 3 feet high. He had to grab the paper, place it on the table, stabilize it with his right hand and press down with the palm of his left hand, using the edge of the table to break the flaps. There were about eight flaps on each side of the paper. He had to press "as hard as [he] could," using his body weight, to break the flaps evenly. T. 61, 63. After doing this for three days, "working as quickly as possible," he was given two helpers "for the second unit." He testified the helpers were not able to break the flaps using their hands and body weight. They had to use screwdrivers and hammers. T. 62. He was not able to use any tools because he would have had to use them with his dominant right hand and the work would have exceeded his restrictions. T. 63.

Petitioner testified that, on March 10, 2017, he was working alone again, on the third unit, performing the same task. As he pushed down on a flap, using his left palm, he felt a pop and stinging sensation in his left shoulder. T. 64. He tried to resume working but was not able to do so. T. 64. He went to the office and reported his injury to three people: John Beyers, a supervisor, "Phil," the quality control superintendent and "another lead person" whose name he was not sure of. T. 66. Beyers completed an accident report the same day. T. 65. Beyers gave Petitioner four ice packs to apply to his left shoulder. Petitioner testified he did not perform any additional work that day. T. 65-66.

Petitioner returned to Dr. Tonino on March 13, 2017. T. 66. The doctor noted that, on March 10th, Petitioner "had another injury to his left shoulder when he was moving some materials and felt a pop and immediate stinging in his left shoulder." He also noted that Petitioner "took Vicodin with no improvement." On examination, the doctor noted elevation to about 120 degrees bilaterally, some pain with rotator cuff testing and some pain with resisted testing of the left biceps. He suspected a left labral tear. He recommended an MR arthrogram of the left shoulder and took Petitioner off work. He informed Petitioner he might require left shoulder surgery. PX 2, p. 538. T. 66-67.

The MR arthrogram, performed on April 4, 2017, showed a supraspinatus tendon tear with an articular-sided tear extending into the intrasubstance delamination and a full-thickness tear extending from the intrasubstance tear to the bursal surface. The radiologist noted no biceps or labral abnormalities. PX 2, pp. 550-551.

On April 10, 2017, Dr. Tonino noted ongoing left shoulder symptoms. He reviewed the MR arthrogram with Petitioner and recommended surgery, indicating Petitioner might need a biceps tenodesis as well as a rotator cuff repair "based on what he had in his right shoulder." PX 2, p. 553. PX 9, Exhibit 9. T. 67.

On June 8, 2017, Dr. Tonino noted that Petitioner remained symptomatic and had not received approval for the recommended left shoulder surgery. On re-examination, he noted pain with resisted palmar abduction with rotator cuff testing. He directed Petitioner to remain off work pending surgery. PX 2, p. 554.

At Respondent's request, Dr. Giannoulias examined Petitioner a fourth time on July 11, 2017. In his report, he indicated that Petitioner described feeling a pop and injuring his left shoulder on March 10, 2017, while tearing a box apart. He also indicated that Petitioner denied having any left shoulder problems prior to that incident. He reviewed the left shoulder MRI images, the Form 45 concerning the left shoulder injury and Dr. Tonino's recent records.

On left shoulder examination, Dr. Giannoulias noted crepitation with abduction and internal rotation, pain with resisted elevation, weakness at 4-/5 and positive Neer's and Lachman's.

Dr. Giannoulias diagnosed Petitioner as having a full-thickness left rotator cuff tear. He attributed this injury to the work accident of March 10, 2017, noting that "no other injury occurred from either the medical records or the examinee's history." He described the tear as acute, based on the MRI images. He characterized the treatment to date as reasonable and necessary. He agreed with Dr. Tonino's recommendation of a left rotator cuff repair. He found Petitioner capable of working so long as he avoided lifting, pushing or pulling more than 5 pounds or performing any overhead work with his left shoulder. He attributed the need for these restrictions to the March 10, 2017 accident. RX 5.

On July 11, 2017, Dr. Tonino noted ongoing left shoulder symptoms. He indicated he was awaiting authorization of the previously recommended surgery. PX 2, p. 555.

On July 28, 2017, Dr. Giannoulias issued a supplemental report, after reviewing surveillance video footage obtained on April 20 and 22, 2017 and certain Facebook photographs. He indicated that the video merely showed Petitioner walking. To him, "it did not appear that [Petitioner] was doing anything substantial outside of his restrictions with his left shoulder." He stated that the opinions he expressed in his last report were unchanged. RX 5.

Petitioner's counsel filed a 19(b) petition and petition for penalties and fees on August 28, 2017. PX 9.

On August 31, 2017, Dr. Tonino noted [apparently incorrectly] that surgery had "finally been approved." He reiterated that there might be biceps as well as rotator cuff involvement. PX 2, p. 556.

Petitioner testified he wants to undergo the left shoulder surgery recommended by Dr. Tonino. He has received no temporary total disability benefits since the March 10, 2017 accident. He has not undergone any conservative care, such as therapy, for his left shoulder. T. 68-69.

On September 26, 2017, Dr. Giannoulias issued a supplemental report, after reviewing Dr. Tonino's most recent records, the left shoulder MR arthrogram and surveillance videos from April and May 2017. Dr. Giannoulias agreed with Dr. Tonino that the left shoulder MR arthogram showed a full-thickness rotator cuff tear. He also agreed with Dr. Tonino's recommendation of a left rotator cuff repair. He indicated the videos added nothing to his opinions since they showed no engagement of the left shoulder. He changed his previous causation opinion based on what he perceived as a "discrepancy in regards to the history." Specifically, he concluded that, because Petitioner had told him at the last examination that he had no left shoulder pain before the March 10, 2017 accident, and because the records showed otherwise, the left rotator cuff pathology was "a manifestation of a pre-existing condition." He indicated that, "regardless of causation," Petitioner required no restrictions with respect to the left shoulder. RX 25.

On September 27, 2017, Respondent issued a check in the amount of $5,326.88. This check represents a permanency advance. RX 9(a).

Respondent filed a response to Petitioner's penalties and fees petition on October 10, 2017. RX 27.

Under cross-examination, Petitioner acknowledged injuring his left hand on January 16, 2005, while working for Flying Food Fare. A cart fell onto his hand. He required surgery and has six screws in the palm of his left hand. He did not injure any other body parts. T. 69.

Petitioner acknowledged working between his March 26, 2014 accident and his December 2014 right shoulder surgery. T. 70. Following the surgery, he returned to work in January 2015, after Dr. Tonino released him to work with no use of the right arm. T. 71. At that point, he worked in Respondent's quality department. When he returned to Dr. Tonino on February 19, 2015, he told the doctor Respondent was making him perform heavy work. T. 71. The doctor took him off work. The doctor told him to avoid any activities involving significant use of his arms. He followed this advice in the spring and summer of 2015. [At this point in the hearing, Petitioner was shown a portion of surveillance video obtained by Respondent on July 4, 2015. This portion shows Petitioner washing a vehicle. A 20-second segment shows Petitioner using his left hand to scrub a wheel and his right hand to lean against the vehicle. Another segment shows the reverse. T. 75-76. At another point, he uses his left arm to reach overhead to clean the top of the vehicle. He also climbs up on the vehicle to use his right arm to reach out from shoulder level. At another point, he carries a bucket which he testified contained only soap and no water. T. 78. Later in the video, he reaches overhead to use a pressure washer and uses both arms to wipe down the vehicle. T. 78-79.]

Petitioner testified he was not subject to any restrictions with respect to his left arm as of 2015. T. 80.

Petitioner testified he returned to light duty in May 2015. He acknowledged he never asked Dr. Tonino whether he could perform one-handed work. T. 81. He kept advising the doctor that Respondent was not accommodating his restrictions. T. 81.

Petitioner testified he typically travels to Mexico at the end of each year, for the holidays. He did not have to change the date of a Section 12 re-examination due to this travel. It was Respondent that kept changing the schedule of the appointment. T. 83.

Petitioner was not sure whether Respondent offered him light duty in January 2016. He did return to work in February 2016. T. 83. At that point, he was assigned to stacking and restacking in the quality department. He also had to go around the facility to check on broken glass, paint quality, etc. T. 84. Respondent told him he could work at his own pace while stacking and restacking but sometimes the customer needed the order as soon as possible, which meant he "had to work faster." T. 84. Respondent did not advise him to stop working if he experienced symptoms. To the contrary, Respondent told him to keep working, saying "you still have one good left arm." T. 84. Some of the light duty he performed consisted of walking around the facility, checking on tooling and measuring tapes with a ruler. T. 85. He agreed this work was not strenuous. T. 86. He also opened a cabinet to check to see whether chemicals and tools were tagged. This was also not strenuous. T. 87. With respect to the stacking and restacking, there was never a time when he simply monitored other workers performing this activity. He was always physically involved in this work. He was able to do this work one-handed. The dusting and cleaning he performed took place "maybe two times a week." He used his left hand to do this work. It would take the entire shift because there are a lot of pipes in the facility. T. 88. With respect to the "breaking flaps" job, Respondent did not tell him he could stop whenever he felt the need to. The job had to be done as quickly as possible. T. 90-91. The ladder he used while putting tubes in slots had wheels. T. 92. He spent most of his light duty time sitting, waiting for assignments. He would ask his supervisor for work. T. 92. During each shift, he was allowed to take a 20-minute lunch break, two 10-minute breaks and one 5-minute break, per union rules. T. 93.

At this point in the hearing, Respondent's counsel showed various job-related videos. Petitioner does not appear in these videos. Petitioner testified that Image 3752 shows the sorting area where he performed stacking and restacking. The bundles he worked on were composed of "mixed sheets," i.e., pieces of paper of different sizes. He could not always flip each sheet. He could do some of the work one-handed, but it depended on the size of the sheet he was dealing with. T. 100. Petitioner testified that Image 1629 shows a worker breaking down flaps. Petitioner testified the video makes the job look easy because the worker is breaking flaps on paper that was not nicked. In contrast, he worked on paper that was nicked, meaning it had been cut into to prevent jamming. He agreed it would not take much force to break flaps on paper that was not nicked. T. 104. He attributes his March 10, 2017 accident to working on paper with "heavy nicking." T. 105. Image 1631 shows a full sheet of tabbed paper. Petitioner testified it is not easier to break flaps or tabs on one sheet at a time. It is actually easier to work on several sheets at a time. If you just take one sheet and try to bend the flaps, "the whole edge" bends in. T. 105-106.

After looking at RX 19, consisting of two forms charting the tasks he performed during two weeks in September and October 2016, Petitioner agreed the tasks were not strenuous. T. 112.

Petitioner acknowledged telling Dr. Giannoulias in September 2017 that he did not have left shoulder symptoms before the March 10, 2017 accident. It was his understanding, based on a letter he received, that the doctor had received all of the information he needed. T. 113. His left shoulder symptoms began in 2015. He saw Dr. Tonino for his left arm in September 2016 and denied any specific accident. T. 113-114. After the March 10, 2017 accident, he felt a pop and stinging in his left shoulder. He was not able to work after the accident. He went home and took a Vicodin. Later that night, his wife threw him a surprise birthday party. T. 115. He identified one of the photographs in RX 20 (page 2) as a photograph of him holding his baby daughter. This photograph was taken late at night on March 10, 2017. His wife was behind him, holding his daughter up. T. 116.

Petitioner testified he has not worked since March 2017. He has not looked for work elsewhere because he is supposed to be employed by Respondent. T. 117. During the times he performed light duty for Respondent, he would sometimes ask to stop due to symptoms. He was not always allowed to stop. Sometimes the customer needed the product and he had to keep working. T. 117-118.

Petitioner testified he has had no right shoulder treatment since December 2016. T. 118.

On redirect, Petitioner testified that Respondent changed the date of a Section 12 re-examination to a day when he was already scheduled to be off for vacation. T. 118. He notified human resources of this since, if he did not take the vacation day as scheduled, he would lose his pay for that day. T. 119. Phil was the only person who gave him light duty assignments. T. 119. During down time, when he was between assignments, he would repeatedly ask Phil and Barbara, Phil's assistant, for work. T. 120. He did not decline any assignments other than the glue removal assignment. T. 121. The party his wife threw for him took place on the night of March 10, 2017. At that time, his daughter was one year old and weighed about ten pounds. He carried her that night for no more than ten to fifteen seconds. He did not lift anything else that night. T. 121-123.

Under re-cross, Petitioner testified the ladder shown in the photographs marked as RX 26, A through E, is not the ladder he used. The ladder he used was eight feet tall. It had wheels. T. 123-124.

Barb Quiroz testified on behalf of Respondent. Quiroz testified she has worked for Respondent for almost ten years. She handles "hard cards," or orders, and customer complaints. She also keeps track of production die cut. T. 128-129.

Quiroz testified she knows Petitioner. She oversaw the light duty work Petitioner performed between 2015 and 2017. T. 129. She gave assignments to Petitioner 90% of the time. T. 131. She and Petitioner worked from 7 AM to 3 PM. Her cubicle was about ten steps away from the desk where Petitioner worked. She could see Petitioner sitting at his desk because the walls of her cubicle were not high. T. 131. Between 2015 and 2017, Petitioner's light duty tasks varied. He put "hard cards" in order, oversaw track numbers, took "low tags" to the office and made lists of workers who performed certain tasks. He also performed audits once a day. This involved walking around while carrying a clipboard and writing serial numbers. He also checked the pH levels once a month. This involved holding a small cup and opening a cabinet door. The audits and pH checks were not strenuous. T. 135. Petitioner also performed sorting. When customers returned paper products that were defective, he separated those products into stacks. The heaviest item he might have handled while sorting was a three-shelf Frito display box that maybe weighed two pounds. T. 136. Once monthly, Petitioner might have been given a rag and told to dust down surfaces, including railings. T. 137. This was not strenuous. Quiroz had no recollection of Petitioner using an industrial mop or broom. T. 138. Petitioner also used a knife to cut bands and peeled shrink wrap off bundles. This was not strenuous. Petitioner also broke flaps on craft boxes. There were two flaps on each side of these boxes. If the "nicks" on the boxes did not break through, you would break the flaps manually. The flaps were not big. No one used tools to break them because, nine times out of ten, that would have caused damage to the box. T. 139-140. Petitioner was told to use his own judgment as to how many to break at one time. Petitioner knew his limitations. "We didn't go out there and watch him the whole time." T. 140. She told him to work at his own pace and take breaks as needed. He was not required to meet any quotas or work at a set pace. T. 142.

Quiroz testified Petitioner spent about an hour or two each day clearing up used Mylar sheets. This involved going to the centers where Mylar was used, rolling a cart to the label room and sliding

tubes into racks. Petitioner was not required to work overhead while doing these tasks. Wheeled ladders were available to him. Pushing one of these ladders was like pushing an empty stroller. Quiroz testified that the photographs marked as RX 26, A through E, show Mylars on racks and a 2-step ladder. T. 145-146.

Quiroz testified that Petitioner spent most of his light duty time in an office, where he used his cell phone or simply "chilled." T. 147.

Quiroz testified she was familiar with Petitioner's restrictions. Petitioner was never asked to exceed those restrictions. The job videos accurately show the light duty tasks Petitioner performed. If Petitioner complained of symptoms, he was not told he had to keep working. Petitioner did not turn down assignments. T. 148.

Under cross-examination, Quiroz testified that Phil Sopicki is Respondent's quality control manager. Sopicki is her boss. Sopicki assigned tasks to Petitioner in her absence. T. 150-151. An upper manager, Mark Welk, is the person who gave her the job of overseeing Petitioner's light duty. When Petitioner performed sorting, he went through boxes to check for defective products. The boxes were bundled ten percent of the time. They were on skids that were 48 inches tall or lower. She has performed sorting but is not sure of the weight of the heaviest bundle. While Petitioner was on light duty, he both observed and performed stacking. T. 153. Petitioner was a good employee. He was helpful to her. He took on all tasks that were assigned to him. Petitioner's assignments emanated from the quality control department but he traveled to other areas to perform those assignments. T. 154.

Quiroz testified she is not familiar with Respondent's "temporary transitional work schedule." She identified the two documents in RX 19 as forms that light duty employees completed and turned in. Phil would sign off on these forms. She could not recall signing off on them. T. 155-156.

On redirect, Quiroz testified that, if an order was banded, it was necessary to cut the band off before removing defective products. She described the bands as "real thin" and made of plastic. T. 158. There were "nine stacks of tens" in each layer. T. 159. Petitioner used his own judgment as to how much weight to lift at any one time. T. 159, 161. Petitioner did not lift anything that weighed more than 5 pounds. T. 161. One box could weigh one pound. No tasks in the quality department involved steel pipes. T. 161.

Emilio Diaz also testified on behalf of Respondent. Diaz testified that Respondent makes corrugated paper and boxes as well as "litho displays." T. 165. He has been Respondent's area manager for two or three years. He oversees, automotons, gluers and safety-related issues. Before that, he was a maintenance manager. That job involved repairing and maintaining the machines and facility. T. 164.

Diaz testified he knows Petitioner. T. 165. Petitioner used to work as a "Bobst" operator for Respondent. He and Petitioner did not work in the same department. T. 166. He (Diaz) used to operate a "Bobst" machine. The job involved setting up jobs and dies according to customers' specifications and running product through the machine. A forklift operator brought materials to the "Bobst" operator. T. 166-167.

Diaz testified he has previously seen RX 28, an analysis of the "Bobst" operator job. T. 168. The job functions and machinery and tools listed on the first page of RX 2 are accurate. The physical demand levels listed on the second page are "pretty much" accurate but some of the percentages are off. T. 169.

A "Bobst" operator spends 1 to 10%, not 30%, of his time kneeling. The 60% assembly percentage is "too high." An operator has to assemble a box only once for each job. The statement as to the heaviest weight lifted, i.e., 25 to 30 pounds, is accurate. The die cast weight range, i.e., 15 to 50 pounds, is also accurate. However, there are two types of "Bobst" machines: small and large. Some of the lifting-related statements on the last page are not accurate. It is not accurate to say an operator never lifts anything weighing less than 10 pounds because "some orders are really small." It could be accurate to say an operator spends 3 to 4 hours per day lifting between 25 and 50 pounds. The carrying-related information, i.e., that an operator spends 1 to 2 hours per day carrying 25 to 50 pounds is "very close" in terms of accuracy.

Diaz had no recollection of Petitioner being assigned to scrape glue off of a pipe around April 2016. Glue is used in the automaton department and with the "posting gluers." T. 173. Diaz testified he took over the automaton department in early 2016. He does not recall Petitioner being there. He mainly works from 7 AM to 3 PM but sometimes works overtime. T. 173-174.

Under cross-examination, Diaz testified he did not create RX 28. He first saw this document a week before the hearing. RX 28 is "very close" to but not the same as the document that is used at Respondent's plant. T. 175. He does not know the weight of a flat bed plate. The plate is on a wheeled track. T. 176-177. It was not directly his job to assign tasks to Petitioner. T. 177.

As noted above, Respondent offered into evidence Petitioner's "temporary transitional work schedule" for the weeks of September 26, 2016 and October 24, 2016. The schedule for the week of September 26th bears Petitioner's notes, initials and signature. The schedule for the week of October 24th also bears the initials of Phil Sopicki. On one day, September 27, 2016, Petitioner was off work due to having to go to court. On the remaining nine workdays, Petitioner indicated he performed various tasks, including checking linear tape, cleaning up a "hold" area, unstocking and restocking skids, putting "hard cards" away, discarding old "mylars" and marking print plates. Petitioner did not describe the precise physical demands of these tasks on the forms. RX 19.

Arbitrator's Credibility Assessment Relative to Both Cases

Petitioner came across as a hard-working individual. The Arbitrator finds credible his testimony that some of the work Respondent directed him to perform was beyond his restrictions. Respondent's witness, Barbara Quiroz, conceded that Petitioner received approximately 10% of his assignments from her boss, Phil Sopicki. Sopicki did not testify. Quiroz also conceded it was Sopicki who signed off on Petitioner's "temporary transitional work schedules" (RX 19). She further acknowledged that Petitioner performed some of his assigned duties outside of the quality control department where she was based. She described Petitioner as a good employee who was helpful to her.

It is the detailed nature of Petitioner's testimony about his assignments that the Arbitrator finds compelling. For example, Petitioner took issue with the portion of Respondent's job video (RX 18, Image 1629) that purportedly showed the "flap" job. He testified the activity looked "easy" on the video because the flaps were not "nicked." The flaps he broke down were "nicked" and the material was heavier. He described a specific three-day interval during which he worked alone, breaking down flaps quickly because of a "time crunch" with the underlying order. Quiroz indicated Petitioner was always allowed to work at his own pace but that testimony is in conflict with Petitioner's testimony that, after the first three days, during which he worked on 7200 pieces, Respondent assigned two people to help him. Those two people ended up having to use hammers or screwdrivers to break down the flaps. T.

62-63. Petitioner could not work in this fashion due to his one-handed restriction. Petitioner's description of the "tubes" job was also detailed and persuasive. While the tubes were not at all heavy, as Petitioner readily conceded, they were 6 to 8 feet long and had to be placed in specific slots. Petitioner testified the slots were above shoulder level. It makes sense to the Arbitrator that Petitioner could have taxed his left arm while working off of a ladder to guide each tube into the correct slot. It also makes sense that Petitioner could have taxed both arms while moving and unbundling sheets of "E-Flu" paper. Neither of Respondent's witnesses contradicted Petitioner's testimony as to the special qualities and weight of this paper.

On only one occasion did Respondent's examiner note any symptom magnification. He described that magnification as "insignificant," given that Petitioner had recently undergone surgery.

Petitioner's testimony concerning his March 10, 2017 accident was also detailed and credible. He testified he provided three supervisors of the accident the same day it occurred. He identified two of these supervisors by name. Neither of them appeared at the hearing. Additionally, the history Dr. Tonino recorded on March 13, 2017 is consistent with Petitioner's account of the accident.

Respondent contends Petitioner was not forthright with Dr. Giannoulias with respect to the timing of the onset of his left shoulder symptoms. In support of this contention, Respondent points to the doctor's re-examination report of July 11, 2017, in which he indicated that Petitioner denied having any left shoulder pain prior to the March 10, 2017 accident. When Petitioner was asked about this at the hearing, he indicated he believed Dr. Giannoulias had reviewed all of his records, since he had already seen the doctor several times. The Arbitrator notes that, when Dr. Giannoulias re-examined Petitioner in October 2016, he was clearly aware that Petitioner's shoulder symptoms were now bilateral. In fact, he specifically addressed causation vis-à-vis the left shoulder. It makes no sense to the Arbitrator that Petitioner would have denied having left shoulder pain before the March 10, 2017 accident when the doctor had already addressed his left shoulder complaints months earlier. The Arbitrator finds the doctor's final opinions of September 26, 2017 (RX 25) persuasive only to the extent that she agrees Petitioner had left shoulder complaints before the March 10, 2017 accident. The Arbitrator attributes these complaints to overuse, secondary to the restrictions relating to the right shoulder, and work conditioning. See further below. Dr. Giannoulias lost credibility, from the Arbitrator's perspective, when he opined, in his final report, that Petitioner requires no left shoulder restrictions despite needing a left rotator cuff repair. RX 25.

Arbitrator's Conclusions of Law in 14 WC 34638

Did Petitioner establish causal connection?

The Arbitrator finds that the undisputed accident of March 26, 2014 resulted in a right shoulder condition that required surgery and revision surgery. The Arbitrator further finds that Petitioner also established causation as to the need for a third surgery, i.e., a right biceps tenodesis, as recommended by Dr. Tonino. Petitioner declined to undergo this surgery, not unreasonably. The Arbitrator further finds that Petitioner established causation as to the need for the permanent restrictions that Dr. Tonino imposed following the valid functional capacity evaluation. Respondent's examiner agreed with the need for permanent restrictions. The Arbitrator assigns no weight to the evaluation-related opinions rendered by Rachel Viel. Viel criticized the evaluator for allegedly failing to use a "legitimate testing method" to determine validity. RX 16. The Arbitrator finds this criticism ironic, given that the evaluation was performed at a facility of Respondent's selection. The Arbitrator assigns some weight to

Diaz's testimony as to the demands of a Bobst operator job but notes the following: 1) Diaz took issue with some aspects of the job description; 2) Diaz conceded there are two types of Bobst machines, i.e., small and large; and 3) it is clear to the Arbitrator, based on Petitioner's credible testimony as to the mechanism of the March 26, 2014 accident, that in the event a plate "derailed," a Bobst operator would have to quickly deal with a weight ten times as heavy as 40 pounds. The job description is deficient in that it does not contemplate the type of situation Petitioner encountered on March 26, 2014.

In rendering the above causation-related opinions, the Arbitrator relies on Petitioner's credible testimony as to the mechanism of injury, Petitioner's credible denial of any prior right shoulder problems, the medical records and the causation-related opinions voiced by Dr. Tonino and Dr. Giannoulias.

The Arbitrator also finds that Petitioner established causation as to some left shoulder and neck complaints that first surfaced in 2015. The Arbitrator attributes these complaints to overuse resulting from the various restrictions Dr. Tonino imposed with respect to Petitioner's use of his dominant right arm. The Arbitrator recognizes that Dr. Giannoulias did not believe Petitioner's quality department tasks could have caused left-sided symptoms. Dr. Giannoulias based this opinion on job videos that Petitioner took issue with.

The Arbitrator further finds that the work conditioning Petitioner underwent in the fall of 2016 led to left arm and neck complaints that required treatment and imaging. In so finding, the Arbitrator relies on the work conditioning records and the notes of Laura Thometz, PA-C, Dorota Pietrowski and Dr. Tonino. Petitioner would not have required work conditioning but for his undisputed right shoulder injury. Respondent's examiner, Dr. Giannoulias, never opined that the work conditioning was unnecessary. Viel conceded it was reasonable for Petitioner to undergo work conditioning for two to four weeks.

Is Petitioner entitled to temporary total disability benefits?

In 14 WC 34638, Petitioner seeks three intervals of temporary total disability: September 29, 2014 through January 8, 2015, February 19, 2015 through March 10, 2016 and June 27, 2016 through December 19, 2016. Respondent disputed this claim at the hearing. Arb Exh 1. The parties agree Respondent paid certain temporary total disability benefits. Those payments are recorded in RX 9.

The Arbitrator notes that, with the exception of RX 19, an exhibit that covers only two one-week periods of employment, neither party offered into evidence any wage or employment records showing the dates Petitioner worked. Such records would have been very helpful. As it is, the Arbitrator is left with Petitioner's testimony, which was sometimes vague or conflicting as to the various dates he resumed working, and the medical records.

With respect to the first claimed interval, the Arbitrator finds Petitioner was temporarily totally disabled from December 2, 2014 (the date of the first right shoulder surgery) through January 8, 2015, a period of 5 3/7 weeks. Under cross-examination, Petitioner acknowledged that, after the March 26, 2014 accident, he continued working for Respondent until his surgery. Respondent is entitled to credit for the benefits it paid (at the rate of $739.87 per week) from December 2, 2014 through January 11, 2015. There was an overpayment during this period.

With respect to the second claimed interval, the Arbitrator finds Petitioner was temporarily totally disabled from February 19, 2015 through May 18, 2015 and again from July 20, 2015 (the date Dr. Tonino took Petitioner off work pending revision surgery) through February 7, 2016. Respondent contends that Petitioner could have performed restricted work after July 20, 2015 but, in the Arbitrator's view, Dr. Tonino had a valid basis for taking Petitioner off work as of that date, given his examination findings and suspicion of a recurrent labral tear. The Arbitrator declines to award benefits from May 19, 2015 through July 19, 2015, as requested by Petitioner, because Petitioner failed to prove he was off work during this period. There is no evidence Petitioner saw Dr. Tonino between April 27, 2015 and July 6, 2015. On July 6, 2015, Dr. Tonino noted that Petitioner had resumed working following a "second opinion," presumably referring to Dr. Giannoulias's re-examination of April 2015. Respondent paid temporary total disability benefits through May 18, 2015.

With respect to the third claimed interval, the Arbitrator finds Petitioner was temporarily totally disabled from June 27, 2016 (the date Dr. Tonino directed him to stay off work while undergoing work conditioning) through September 22, 2016 (the date Dr. Tonino released him to restricted duty). Respondent paid no temporary total disability benefits during this period. RX 9. The Arbitrator finds it reasonable for Dr. Tonino to have kept Petitioner off work while engaging in work conditioning. Dr. Giannoulias and Vial agreed with the need for work conditioning. Petitioner encountered two legitimate problems while attempting to pursue work conditioning: 1) he changed facilities due to ATI being closer to his house; and 2) he began experiencing left arm and neck problems after switching to ATI, which prompted Dr. Tonino to place the regimen on hold and order various consultations and tests.

Is Petitioner entitled to reasonable and necessary medical expenses?

In 14 WC 34638, Petitioner claims various unpaid medical bills. Arb Exh 1. PX 2(a). PX 8(a).

Petitioner offered into evidence a large collection of bills from Loyola University Medical Center. PX 2(a). These bills relate to treatment provided between September 8, 2014 and December 19, 2016. Many of the bills show $0 balances. Some, including bills for therapy and imaging performed in 2016, show balances. Respondent asserts Petitioner "is not entitled to any allegedly unpaid medical bills." Respondent offered into evidence a lengthy print-out of the medical payments it made in this case. RX 10. Petitioner raised no objection to RX 10. Petitioner's counsel made no effort to specify which of the many Loyola bills remain unpaid and Respondent's counsel made no effort to coordinate his client's payments with the claimed bills.

The Arbitrator has previously found that Petitioner established causation as to a right shoulder condition that required surgery and as to left shoulder and cervical spine complaints that required imaging and work-up. The Arbitrator further finds that the care underlying the bills in PX 2(a) was reasonable and necessary. In none of his many reports did Respondent's examiner opine that Petitioner's care was unreasonable or excessive.

The Arbitrator awards Petitioner the bills in PX 2(a), subject to the fee schedule and with Respondent receiving credit for the payments reflected in RX 10.

Petitioner also claims a $3,500.00 bill from Oak Brook X-ray and Imaging. This bill relates to the cervical spine MRI of November 8, 2016 (PX 8(a)). It does not appear on Respondent's payment print-out. As noted above, the Arbitrator has previously found that Petitioner established causation as to

cervical spine symptoms that warranted imaging and evaluation. The Arbitrator awards Petitioner the Oak Brook X-ray and Imaging bill in the amount of $3,500.00, subject to the fee schedule.

Is Petitioner entitled to prospective care?

Petitioner placed prospective care at issue in this case but, as of the hearing, the only pending treatment was left shoulder surgery recommended by Drs. Tonino and Giannoulias. See the Arbitrator's prospective care award in 17 WC 7694, below.

Is Respondent liable for penalties and fees?

In 14 WC 34638, Petitioner seeks penalties and fees on both temporary total disability benefits and medical expenses. With respect to the former, the Arbitrator notes that when Respondent paid Petitioner benefits, it paid them at the rate of $739.87 per week. RX 9. At the hearing, the parties stipulated to an average weekly wage of $1,083.56 in both cases. Arb Exh 1-2. This wage gives rise to a slightly lower temporary total disability rate of $722.37. The Arbitrator has considered this, along with the total payments reflected in RX 9 and RX 9(a), the underlying disputes and the uncertainty as to some of the dates Petitioner was off work, in evaluating Respondent's liability for penalties and fees. The Arbitrator again notes she was not provided with time cards or payroll records. While an employer bears the burden of showing it acted in an objectively reasonable manner in disputing the payment of temporary total disability benefits, once penalties and fees are placed at issue, the claimant has the initial burden of proving when he was off work due to his injury.

The Arbitrator finds that Respondent is liable for Section 19(l) penalties in the amount of $5,070.00 (169 days x $30/day) based on its late payment of temporary total disability benefits covering the post-operative period October 21, 2015 through December 20, 2015. Respondent did not issue these benefits until April 7, 2016. RX 9. There was a delay of 169 days between October 21, 2015 and April 7, 2016. Section 19(l) penalties are in the nature of a mandatory late fee. Oliver v. IWCC, 2015 IL App (1st) 143836WC.

The Arbitrator further finds that Respondent is liable for additional Section 19(l) penalties in the amount of $4,930.00 (the balance of the statutory $10,000 maximum) based on its failure to pay any temporary total disability benefits for the period June 27, 2016 through September 22, 2016 prior to the hearing of January 12, 2018.

The Arbitrator declines to award penalties and fees on the awarded medical bills because Petitioner offered no evidence of a "written demand for payment" of any of these bills, as required by Section 19(l). Petitioner's penalties/fees petition simply sets forth a generic demand for payment of medical expenses. PX 9.

Arbitrator's Conclusions of Law in 17 WC 7649

Did Petitioner sustain an accident on March 10, 2017 arising out of and in the course of his employment? Did Petitioner provide timely notice of said accident?

The Arbitrator, having considered Petitioner's credible and unrebutted testimony along with Dr. Tonino's note of March 13, 2017 and the Facebook photographs (RX 20) offered by Respondent, finds that Petitioner sustained an accident on March 10, 2017 arising out of and in the course of his

employment. Petitioner testified the accident occurred while he was on Respondent's premises, performing a work-related task (i.e., removing flaps from paper products). The two witnesses who testified for Respondent did not refute Petitioner's account of the accident.

The Arbitrator further finds that Petitioner provided timely notice of the accident. Petitioner credibly testified he notified three supervisors/managers of the accident the same day it occurred. He further testified that one of these individuals completed an accident report. That testimony is buttressed by Dr. Giannoulias's reference to a Form 45 "that did confirm an injury on March 10, 2017." RX 5. None of the three individuals Petitioner identified appeared at the hearing.

In finding accident and timely notice, the Arbitrator has considered the Facebook photographs offered by Respondent. These photographs show Petitioner at his surprise birthday party on the night of March 10, 2017. One shows Petitioner holding his one-year-old daughter but he is holding her on the right side of his body. It appears to the Arbitrator he is using his left hand/arm only for support. Petitioner testified the photograph was taken after he took a Vicodin that provided pain relief. He also testified he carried his daughter for only 10 to 15 seconds and did not lift anything else that night. The photograph does not undermine Petitioner's credible account of the accident.

Did Petitioner establish a causal connection between the March 10, 2017 accident and the need for the left shoulder surgery recommended by both Dr. Tonino and Respondent's examiner?

The Arbitrator finds that the accident of March 10, 2017 was a cause of Petitioner's current left shoulder condition of ill-being and contributed to the need for the left rotator cuff repair recommended by both Dr. Tonino and Dr. Giannoulias, Respondent's examiner. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony as to the mechanics of the accident; 2) Petitioner's credible testimony that he experienced a pop and a stinging sensation in his left shoulder after the accident; 3) the history that Dr. Tonino recorded on March 13, 2017; 4) the results of the December 2016 left shoulder MRI and April 2017 left shoulder MR arthrogram; and 5) Dr. Giannoulias's original opinion that the accident caused the full-thickness left rotator cuff tear demonstrated on the MR arthrogram. RX 5.

The Arbitrator recognizes that Petitioner experienced left shoulder symptoms at various times prior to March 10, 2017. The earliest mention of such symptoms was in February 2015. Left-sided symptoms are also documented in the 2016 work conditioning records. The Arbitrator also recognizes that Dr. Giannoulias did not link those symptoms to Petitioner's quality department job activities when he re-examined Petitioner in October 2016. The Arbitrator notes Dr. Giannoulias based this opinion, at least in part, on job videos which Petitioner described as inaccurate, in terms of the specific tasks he performed and the materials he used.

In short, the Arbitrator views Petitioner's current left shoulder condition as multi-factorial, with pre-accident work duties, work conditioning and the March 10, 2017 accident contributing to the condition. In Illinois, it has long been held that an accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003).

Is Petitioner entitled to temporary total disability benefits?

In 17 WC 7694, Petitioner claims he was temporarily totally disabled from March 13, 2017 through the hearing of January 12, 2018. Respondent disputes this claim based on its accident and causation defenses. The Arbitrator has previously found that Petitioner established accident and causation. There is no dispute that Petitioner has a left rotator cuff tear and requires surgery. In his report of July 28, 2017, Respondent's examiner, Dr. Giannoulias agreed with Dr. Tonino's surgical recommendation but found Petitioner capable of very light duty with no lifting, pushing or pulling over 5 pounds and no overhead work using the left shoulder. RX 5. In his supplemental report, issued the same day, he indicated his opinions remained unchanged after reviewing surveillance videos from April 2017 (RX 12) and the March 10, 2017 Facebook photograph. RX 5. In his final report, issued September 26, 2017, he again found Petitioner to be a surgical candidate. The Arbitrator views Petitioner's causally related left shoulder condition as unstable. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). The Arbitrator finds it reasonable for Dr. Tonino to have kept Petitioner off work since March 13, 2017, in light of the previous significant right shoulder problems, the permanent restrictions relative to the right shoulder and the need for left shoulder surgery. The Arbitrator gives no weight to Dr. Giannoulias's opinion that Petitioner requires no restrictions relative to his left shoulder even though he needs a left rotator cuff repair.

Is Petitioner entitled to reasonable and necessary medical expenses?

On the Request for Hearing form in 17 WC 7694 (Arb Exh 2), Petitioner indicated he was claiming bills in PX 2(a) [Loyola] and PX 8(a) [Oak Brook X-ray and Imaging]. These bills do not include charges for treatment rendered after the March 10, 2017 accident. The Arbitrator has previously awarded the bills in 14 WC 34638 [see above].

Is Petitioner entitled to prospective care?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Drs. Tonino and Giannoulias agree that Petitioner has a left rotator cuff tear and requires surgery. The Arbitrator awards prospective care in the form of left shoulder surgery.

Is Respondent liable for penalties and fees?

The Arbitrator declines to award penalties and fees in 17 WC 7694. The Arbitrator does not view Respondent's accident and causation defenses as objectively unreasonable under all of the existing circumstances. Petitioner was working alone at the time of the March 10, 2017 accident, by his own admission. Moreover, Respondent had some basis, i.e., Quiroz and the "flaps" video/image, for questioning whether the task Petitioner was performing at the time of the accident could have given rise to the injury. The Arbitrator accepts Petitioner's account (i.e., that the video is inaccurate in that he was working with heavy, "E-Flu" paper and hurrying to meet a customer's demands) but is unable to find that Respondent acted vexatiously in relying on Quiroz and the video.

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

Kimberly Reeves,
Petitioner,
vs.

NO: 17 WC 26099

Walmart,
Respondent.

18IWCC0553

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 18, 2018, 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.

SEP 7 - 2018

DATED:
o083018
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

REEVES, KIMBERLY
Employee/Petitioner

Case# **17WC026099**

WAL-MART
Employer/Respondent

18IWCC0553

On 1/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% 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:

0243 JAMES ELLIS GUMBINER & ASSOC
CHRISTOPHER COOPER
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

5074 QUINTAIROS PRIETO WOOD & BOYER
RACHEL BECICH
233 S WACKER DR 70TH FL
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)

Kimberly Reeves
Employee/Petitioner
v.
Wal-Mart
Employer/Respondent

Case # 17 WC 026099

18IWCC0553

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **December 6, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **July 23, 2017**, 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 **$12,062.86** the average weekly wage was **$309.30.**

On the date of accident, Petitioner was **52** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on July 23, 2017 and failed to prove that there is a causal connection between any such alleged injury and her current condition of ill-being regarding her right wrist.

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

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

Signature of Arbitrator

January 17, 2018
Date

ICArbDec19(b)

JAN 18 2018

FINDINGS OF FACT

Petitioner was employed by Respondent as a cashier. She had been so employed since October 24, 2016.

Petitioner testified that she was ringing up a customer and picked up a case of beer and heard her wrist pop on July 23, 2017. Petitioner stated that the case of beer was the biggest case of beer that Wal-Mart carried and stated that she knew it was a case and that the case contained cans. The case was heavy. Petitioner described using two hands to pick up the case of beer by the handles on the side of the case. Petitioner testified that she grabbed the case fast and lifted the total weight of the case of beer in her hands and that she dropped the case back onto the register. Petitioner testified that this incident happened at the beginning of her shift. This was her first customer. Petitioner testified that after the incident she felt pain in her wrist and her wrist swelled up "like a balloon. The pain was throbbing.

Petitioner testified that she had no wrist pain before she started work. Her wrist was not swollen, either. She had no incidents of prior wrist pain. Petitioner is left handed.

Petitioner testified that she immediately advised her manager, Reka, about the incident. Reka saw the swelling in Petitioner's wrist. Petitioner also advised manager Mike about the incident. She asked to be excused to go to the emergency room. Petitioner stated that she stayed until the end of her shift and then immediately went to the emergency room. Petitioner was concerned about be assessed points for leaving early. She had attendance points pending against her already. Petitioner made a sling with some scarves and completed her shift.

Petitioner testified that she first sought treatment at Little Company of Mary Hospital. She testified that she informed Little Company of Mary that she was at work, picked up a case of beer and injured her wrist. An x-ray was performed and they told her that her right wrist was broken. They gave her Tylenol 3, casted her arm and told her to follow-up with an orthopedist. The records of Little Company of Mary show that Petitioner presented to the ER at 12:06am on July 24, 2017. She presented for "I think I broke my arm." The history was that she was lifting a 30 pack of year (sic) (beer?) at work and felt a pop. The physical exam revealed tenderness and swelling in the hand, fingers, wrist and distal forearm. An x-ray showed a non-displaced distal radius fracture with a questionable ulnar styloid fracture. (RX 2)

Petitioner testified that she was then seen in follow-up by Dr. Schlenker at Hand & Plastic Surgery. She stated that she informed Dr. Schlenker that she was working ringing up a customer and picked up a case of beer and heard a pop in her wrist. She testified that Dr. Schlenker told her that she needed surgery. The records of Hand & Plastic document that Petitioner presented for treatment with Dr. James D. Schlenker on July 27, 2017. The treatment note indicates that Petitioner provided a history of a work injury sustained on July 22, 2017. The narrative states that at that time Petitioner was working as a cashier and was attempting to lift a heavy case of beer when she felt a "pop" followed by immediate pain and swelling of the right wrist. Dr. Schlenker diagnosed Petitioner with a comminuted fracture of the distal radius and recommended open

reduction internal fixation of the fracture of the distal radius and application of an external fixator with the possibility of internal fixation of the distal ulna fracture. Dr. Schlenker's Clinic Note of July 27, 2017 states that he was concerned about Petitioner's history regarding her fracture and whether it occurred while lifting a case of beer at work. Dr. Schlenker indicated that the wrist fracture looked like it was the result of a die punch injury from an axial force and not from lifting. Dr. Schlenker spoke with APN Sarah Chewning, who examined Petitioner at Little Company of Mary Emergency Room on July 27, 2017. Dr. Schlenker noted that APN Chewning distinctly remembered Petitioner because she also wondered how the fracture could occur as a result of lifting a case of beer. APN Chewning went on to state that Petitioner told her that she felt a "pop" at the beginning of her shift, informed her supervisor and was forced to work the rest of her shift. APN Chewning asked Petitioner how she was able to continue work and Petitioner told her she made a sling out of a scarf and continued to work using her left hand. APN Chewing stated that Petitioner did not tell her that she had a back problem from work and was on Gabapentin, although the patient did tell her she was taking Norco. (PX 2)

Petitioner testified that she was originally scheduled to have right wrist surgery performed by Dr. Schlenker. The surgery was cancelled.

Petitioner stated that as of the date of her testimony that she had underwent surgery with a different doctor at Illinois Orthopedic Network. Petitioner testified that she informed Illinois Orthopedic Network that she was at work, picked up a case of beer and heard a pop in her wrist. The ION records show that Petitioner first sought treatment with PA Brittany Macleod on August 7, 2017. The records indicate that Petitioner was seen for an initial evaluation of an injury sustained at work. The narrative contained in the treatment record states that Petitioner was a Wal-Mart cashier, picking up a case of beer and her hand kind of got stuck in the handle, she heard a pop with extreme pain in the wrist. Petitioner was diagnosed with a distal radius fracture. (PX 3)

Petitioner underwent surgery on her right wrist, on September 14, 2017, by Dr. Irvin Weisman of ION. He performed an open reduction and internal fixation with Medartis volar plate. The indication for surgery is listed as "this is a female who fell and suffered a comminuted and displaced right distal radius fracture and repair." (PX 3, 4)

Petitioner testified she currently was unable to lift or pick up anything heavy with the right wrist. She stated that she could not use her right hand at all because it still hurt. She has 9/10 wrist pain.

On cross-examination, Petitioner testified that she had been truthful and honest with the medical providers who have treated her and agreed that the purpose of being truthful and honest was for the purpose of getting better. Petitioner also testified that she provider her doctors a truthful and complete history of how her accident occurred and that the purpose of providing a truthful and complete history was in order to be diagnosed properly in order to get better.

Wal-Mart Assistant Manager Lauren Tamba, testified at Respondent's request. She is employed at Wal-Mart store 5781 and has worked there for 11 years. She worked as an assistant manager for the past 5 years. Ms. Tamba stated that her job duties included overseeing her department, making sure everyone was on routine, verifying stock and helping customers as needed. Ms. Tamba testified that she was the assistant manager on duty on July 23, 2017 and that

the security cameras were in working order on that date. Ms. Tamba testified that there were specific tasks required of her when an accident was reported including filling out paperwork, obtaining witness statements and saving video footage captured at the time of the alleged accident. Tamba was familiar with Petitioner, an associate at her store.

Video footage of the alleged incident on July 23, 2017 was admitted into evidence at trial. (RX 1) Tamba testified the video was kept in the course of Wal-Mart's regularly conducted business and was a true and accurate representation of the events that took place on July 23, 2017. Tamba testified that she personally reviewed the video evidence. RX 1 was a fair and accurate reproduction of what Petitioner saw on the video. The video had not been edited or altered. The video was first viewed by manager Michael and then Tamba. Ms. Tamba identified Petitioner as the person depicted on the video.

Ms. Tamba testified about three separate video clips in which she identified Petitioner. Ms. Tamba reviewed video evidence with a date / time stamp of July 23, 2017 / 5:18 pm. The Arbitrator labels this as Clip 1. Ms. Tamba described Clip 1 as depicting Petitioner's movements at the register and the use of her left hand. On cross-examination Ms. Tamba again described Petitioner as mainly using her left hand at the time stamp of 5:18 pm. Ms. Tamba reviewed video evidence with a time / date stamp of July 23, 2017 / 5:46 pm. Ms. Tamba describes Petitioner as not using her right hand and mainly using her left hand. Finally, Ms. Tamba identified video evidence with a date / time stamp of July 23, 2017 / 5:53 pm. Tamba describes Petitioner as using her left hand to check bags and sign onto the register. Petitioner was checking to make sure that she had everything at her register. Petitioner was shown with a bottle of water which she switches to her left hand to close. Petitioner had difficulty putting on a glove. Petitioner is seen ringing out a customer with a 12 pack of beer. Ms. Tamba testified that Petitioner predominately used her left hand for most of the tasks she did at the register and that the use of her right hand was guarded Ms. Tamba testified that Petitioner was unable to pick up the beer and that she did not pick it up all the way. (RX 1)

The Arbitrator viewed the video at trial and notes the following. Petitioner goes to her work station and does appear to be favoring her right hand. She has trouble putting a glove on her right hand and putting a top on a water bottle. Clip 3 shows Petitioner at her register at 5:52pm. She has her first customer at 5:56pm. Her second customer has a 12-pack of Amstel beer bottles. Petitioner appears to have trouble with the beer. She does not pick it up with 2 hands. She does not pick up the 12-pack very much at all.

Petitioner chose not to provide any rebuttal testimony regarding the video.

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS

305/1(b)3(d). 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)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

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)

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:

Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on July 23, 2017.

Petitioner's testimony is found to be not credible. The video clearly shows Petitioner to be favoring her right hand prior to waiting on customers. Further, the video shows that the customer that presented to Petitioner with beer was her second customer, not the first customer. The beer was a 12-pack of bottles, not a case of cans, and not a 30-pack of cans. She does not pick up the beer with 2 hands and there does not appear to be a sudden failure of the hand that one would associate with a "pop" and the immediate onset of pain and swelling. Petitioner testified that she gave honest and complete histories to her medical treatment providers. Her histories are inconsistent with the video evidence. Falsus in uno, falsus in omnibus. McDonald v. Industrial Commission, 39 Ill.2d 396 (1968) Petitioner's failure of proof can be established by her non-credible testimony alone.

Additionally, the Arbitrator relies on the medical records in denying the claim. Dr. Schlenker documents that the fracture that Petitioner has is inconsistent with the accident that she described. He confirmed his concerns by consulting with the APN that saw Petitioner at Little Company of Mary. Dr. Schlenker's Clinic Note indicating that the pathology is consistent with a die punch type axial trauma is persuasive and convinces the Arbitrator that the injury did not occur as it was described by Petitioner. The x-ray findings are consistent with a fall or a blunt trauma.

Finally, Dr. Weisman's operative note of September 14, 2017 documents the history of a female who fell and suffered a comminuted and displaced right distal radius fracture. This history is consistent with the pathology and is not consistent with Petitioner's testimony and the histories to the ER, Dr. Schlenker and the initial history to ION.

The claim for compensation is, therefore, denied.

With regard to Issue (F), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds:

The Arbitrator finds that Petitioner's current condition of ill-being regarding her right hand is not causally related to the claimed accident of July 23, 2017, based upon the Arbitrator's finding above regarding the issue of accident. No accident occurred, so nothing can be causally related.

Additionally, Dr. Schlenker's opinion that the wrist pathology is consistent with a blunt force trauma is persuasive and offers further support of this finding. Finally, it is to be noted that none of Petitioner's treating physicians have stated that her right wrist fracture is causally related to her described accident.

With regard to Issue (J), Were the medical services that were provided to Petitioner reasonable and necessary, and Issue (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds:

Petitioner's claims for incurred and prospective medical expenses is denied, based upon the Arbitrator's findings above regarding the issues of accident and causation.

With regard to Issue (M), Should any penalties or fees be imposed on Respondent, the Arbitrator finds:

For the reasons stated above, the Arbitrator denies Petitioner's claims for penalties and attorney's fees.

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

Paula Tagler,
Petitioner,

vs. NO: 15 WC 36032

Cook County School District #130,
Respondent.

18IWCC0554

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 19, 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: SEP 7 - 2018
o083018
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TAGLER, PAULA
Employee/Petitioner

Case# **15WC036032**

COOK COUNTY SCHOOL DISTRICT #130
Employer/Respondent

18IWCC0554

On 11/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2093 BARRETT & SRAMEK
MICHAEL B BARRETT
6446 W 127TH ST
PALOS HGTS, IL 60463

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL R SIMONES
20 N CLARK ST SUITE 1000
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

PAULA TAGLER,
Employee/Petitioner

Case # **15 WC 36032**

v.

Consolidated cases:

COOK COUNTY SCHOOL DISTRICT #130,
Employer/Respondent

18IWCC0554

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 **10/17/2017**. 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

FINDINGS

On 4/17/2013, 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.

ORDER

As the Arbitrator finds that the Petitioner did not sustain an accident that arose out of and in the course of her employment, benefits are denied under the Illinois Workers' Compensation Act.

The Arbitrator finds that the issues of causal connection, medical bills, TTD benefits, the nature & extent of the Petitioner's injuries, and Respondent's credit are moot given the findings with respect to the issue of 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.

Signature of Arbitrator

11·28·17
Date

NOV 29 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAULA TAGLER,

Petitioner,

v.

COOK COUNTY SCHOOL DISTRICT #130,

Respondent.

Court No. **15 WC 36032**

18IWCC0554

MEMORANDUM OF ARBITRATOR'S DECISION

FINDINGS OF FACT

On October 22, 2015, the Petitioner was working as a Kindergarten teacher at Nathan Hale Elementary (Tr. 10-11). Petitioner worked as a Kindergarten teacher for 45 years prior to that date (Tr. 11). Prior to the 2015 school year, she put in her retirement papers and the 2015/2016 school year was to be Petitioner's last year working as a Kindergarten teacher (Tr. 65).

On October 22, 2015, she was scheduled to work an afterschool extracurricular event called The Night of Reading (Tr. 15-16). Petitioner's duties for The Night of Reading involved making snacks at home and bringing them to the school (Tr. 17-18). She drove the snacks to the school and left them in her car during the normal school day (Tr. 18).

After the school day was over, the Petitioner and a co-worker, Michelle Szukalski, went to her car to retrieve the snacks (Tr. 18-19). Ms. Szukalski pushed a cart to the Petitioner's car, on which she intended to carry the snacks (Tr. 19-20). The Petitioner and Ms. Szukalski loaded the snacks onto the cart and Ms. Szukalski pushed the cart back towards the school (Tr. 22). The Petitioner testified that Ms. Szukalski walked faster than her. However, they were not late for the event, Ms. Szukalski was not running, and the Petitioner walked at a normal pace (Tr. 52). Ms.

Szukalski carried all of the snacks on the cart and the Petitioner did not have anything in her hands (Tr. 50-51).

As the Petitioner and Ms. Szukalski approached the school, there is a sidewalk with a handicapped accessible section leading to the front door (Tr. 26-27). While approaching the sidewalk and crossing the handicapped accessible area, the Petitioner fell forward landing on her left shoulder (Tr. 29).

Petitioner testified that, "I don't even know if I caught my foot on the curb or on the little nubs . . . I know my foot caught, like caught itself, the sole did, but I can't say that [there was] uneven concrete (Tr. 56)." Petitioner testified that there were not any foreign objects or debris around the area that she fell and that there were no broken chunks of sidewalk (Tr. 58-59).

Petitioner heard a "crack" and felt immediate pain after her fall (Tr. 30). Petitioner's husband lives close to the school and arrived at the scene to take her to the Palos Hospital Emergency Room (Tr. 32). X-rays taken at the ER revealed a broken humerus bone (Tr. 34; PX 3).

On November 5, 2015, the Petitioner saw Dr. Leonard at Midwest Orthopaedic Consultants, who recommended surgery and removed the Petitioner from work (Tr. 37-38; PX4). Dr. Leonard performed surgery at Christ Hospital on November 10, 2015, consisting of open reduction and internal fixation of the left proximal humerus (PX5). Petitioner testified that Dr. Leonard implanted a plate and 11 screws into her upper arm (Tr. 39).

Petitioner returned to Christ Hospital on November 13, 2015 secondary to swelling in her hand and arm. She testified that she was concerned there was a blood clot. However, diagnostic testing revealed that she did not suffer from a blood clot (Tr. 39-40; PX6).

Post-operatively, the Petitioner attended periodic follow up visits with Dr. Leonard and physical therapy at Achieve Manual Physical Therapy (Px4; PX10). On December 29, 2016, Dr. Leonard released the Petitioner to return to work at full duty effective January 5, 2016; after the school's holiday break (Tr. 43-44; RX4). Petitioner attended 46 physical therapy visits through May 24, 2016 (Tr. 42; PX10). Petitioner has not had any therapy or seen any physicians regarding her shoulder since she was discharged from therapy (Tr. 43). Petitioner testified that she performs home exercises (Tr. 43).

Petitioner retired at the end of the 2015/2016 school year (Tr. 65). She testified that she intended to retire prior to suffering her fall and regardless of it (Tr. 65). Petitioner further testified that she continues to work periodically; substitute teaching at Nathan Hale Elementary School (Tr. 65). She testified to difficulties writing on a chalkboard and lifting heavy objections secondary to her injuries (Tr. 45). However, she indicated that she was able to work regular duty as a teacher through her retirement and able to work as a substitute teacher (Tr. 63-65).

Petitioner testified that she had group medical coverage through her employer with BlueCross BlueShield of Illinois (Tr. 62). All of her medical bills were submitted for payment through her group medical plan (Tr. 62). Her group carrier paid $40,457.68 in medical bills (Arb. Ex. 1). Petitioner's medical providers have outstanding balances totaling $1,354.80 (Arb. Ex. 1).

Petitioner missed work from October 23, 2015 through January 4, 2016 (Tr. 60). She first received an off work slip on November 5, 2015 when she saw Dr. Leonard (Tr. 60). Petitioner received her full salary while she was off of work (Tr. 61). She testified that she used sick days from October 23, 2015 through December 18, 2015 (Tr. 61). Petitioner received her regular pay without using sick days from December 19, 2015 through January 4, 2016 during the school's winter break (Tr. 61). Petitioner testified that teachers are given 13 days at the

beginning of each school year and may use them for personal or sick days throughout the year (Tr. 61-62). The days are provided by the employer and may be used for any reason and are not limited to use during occupational injuries (Tr. 62).

Respondent entered a witness statement authored by Ms. Szukalski into evidence (RX1). Petitioner agreed with Ms. Szukalski's recollection of the events of her fall (Tr. 54-56). Respondent entered pictures of the area where Petitioner fell into evidence (RX 2-5). Petitioner testified that the pictures accurately depict the area where she fell (Tr. 58).

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that the Petitioner did not suffer an accident that arose out of and in the course of her employment with the Respondent. The claimant has the burden of establishing by a preponderance of the evidence that her injury arose out of and in the course of her employment. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980).

Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing her duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment. *Caterpillar Tractor Co v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989).

The Petitioner was retrieving snacks from her car for an after school function at the time of her fall. The Arbitrator finds that the fall did occur in the course of her employment.

However, the fact that the injury occurred in the course of the employment is not sufficient to impose liability. To be compensable, the injury must also "arise out of" the employment. *Id.* at 58. There are three categories of risk to which an employee may be exposed;

namely: (1) risks distinctly associated with her employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Comm'n,* 314 Ill.App.3d 149, 162 (1st Dist. 2000). The risk of tripping on a sidewalk is not distinctly associated with employment, nor is it personal to a petitioner. The risk of tripping on a sidewalk is a neutral one. *Litchfield Healthcare Center v. Industrial Comm'n,* 349 Ill. App. 3d 486, 490 (5th Dist. 2004)

Consequently, the question of whether the claimant's injury arose out of her employment rests on a determination of whether she was exposed to a risk of injury to a greater extent than that to which the general public was exposed. *Illinois Institute of Technology,* 314 Ill.App.3d at 162.

If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, it is not compensable. *Caterpillar Tractor Co.*, 129 Ill.2d at 59.

The Arbitrator finds that the Petitioner's fall did not arise out of her employment with the Respondent as she was not exposed to a risk greater than that of the general public.

In reaching this determination, the Arbitrator relies on Respondent's Exhibits 2-5 which are pictures of the sidewalk where the Petitioner fell (RX2-5). Petitioner testified that the pictures accurately depict the area where she fell (Tr. 58). The pictures reveal a normal sidewalk, curb, and handicap accessible ramp area. There are no uneven sections of the sidewalk, curb, or ramp. There were no puddles, ice, or other debris located on the sidewalk, curb, or ramp.

Petitioner drew an "X" and circled where she fell on Respondent's Exhibit 2 (Tr. 57.). Petitioner testified that, "I don't even know if I caught my foot on the curb or on the little nubs . . . I know my foot caught, like caught itself, the sole did, but I can't say that [there was] uneven

concrete (Tr. 56)." Petitioner testified that there were not any foreign objects or debris around the area that she fell and that there were no broken chunks of sidewalk (Tr. 58-59). The Petitioner testified that she was not carrying anything in her hands at the time of her fall (Tr.50-51). She further testified that she was not late or in a rush and was walking at a normal pace (Tr. 52).

The Petitioner's testimony in conjunction with Respondent's Exhibits 2-5 establish that she was not exposed to a risk greater than that of the general public and that her accident did not arise out of her employment. Therefore, compensation is denied.

In support of the Arbitrator's Decision with regard to whether Petitioner's current condition of ill-being is causally connected to the injury or exposure, the Arbitrator makes the following conclusions of law:

As the Petitioner did not suffer a compensable work accident, the Arbitrator finds that Petitioner's condition of ill-being is not causally connected to the injury or exposure.

In support of the Arbitrator's Decision with regard to whether Respondent is liable for unpaid medical bills, the Arbitrator makes the following conclusions of law:

As the Petitioner did not suffer a compensable work accident, the Arbitrator finds that Respondent is not liable for unpaid medical bills.

In support of the Arbitrator's Decision with regard to whether Petitioner is entitled to Temporary Total Disability benefits, the Arbitrator makes the following conclusions of law:

As the Petitioner did not suffer a compensable work accident, the Arbitrator finds that Petitioner is not entitled to Temporary Total Disability benefits.

In support of the Arbitrator's Decision with regard to whether Respondent is entitled to a credit under Section 8(j) of the Act, the Arbitrator makes the following conclusions of law:

As the Petitioner did not suffer a compensable work accident, the Arbitrator finds that the 8(j) credit issue is moot.

In support of the Arbitrator's Decision with regard to what is the nature and extent of the Petitioner's injuries, the Arbitrator makes the following conclusions of law:

As the Petitioner did not suffer a compensable work accident, the Arbitrator finds that the 8(j) credit issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Arizpe,

Petitioner,

vs. NO: 16 WC 16348

18IWCC0555

Labor Network,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 29, 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.

18IWCC0555

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: SEP 7 - 2018
o083018
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

ARIZPE, MARIA
Employee/Petitioner

Case# **16WC016348**

LABOR NETWORK
Employer/Respondent

18IWCC0555

On 12/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5755 COSTA IVONE LLC
JULIO COSTA
6847 W CERMAK RD
BERWYN, IL 60402

5001 GAIDO & FINTZEN
PETER HAVIGHORST
30 N LASALLE ST SUITE 3010
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)
X None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARIA ARIZPE
Employee/Petitioner

v.

LABOR NETWORK
Employer/Respondent

Case # **16** WC **16348**

Consolidated cases: **D/N/A**

18IWCC0555

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 **11/16/17**. 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 _____

18IWCC0555

FINDINGS

On the date of accident, **4/20/16**; Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to a right elbow condition that requires surgery and as to neck, shoulder, left elbow and wrist conditions requiring conservative care. The Arbitrator further finds that Petitioner did not establish causation as to the low back condition referenced in Dr. Poepping's records. PX 7.

Petitioner's average weekly wage was **$479.29.** See the attached decision for an explanation of the Arbitrator's calculation.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$0** 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 **$N/A** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits at the rate of $319.52 per week during two intervals: 6/1/16 through 7/13/16 (with the exception of the two days Petitioner worked during this period, RX 3) and 8/3/16 through the hearing of 11/16/17. These two intervals total 73 1/7 weeks.

Respondent shall pay the following reasonable and necessary medical/prescription expenses, subject to the fee schedule: 1) M & R Rudra New Life Medicine, $1,535.00; 2) IWP, $987.07; 3) Edgebrook Open MRI, $11,084.00; 4) G & T Orthopedics, $1,870.00; 5) Midwest Anesthesia & Pain Specialists, $2,759.86; 6) Windy City RX, $5,819.30; 7) Illinois Anesthesia Specialists, $1,736.00; 8) Windy City Medical Specialists, $250.00; 9) Physical Therapy Associates, $28,870.00; and 10) Hyde Park Same Day Surgicenter, $10,000.00. See the attached decision for an explanation of the Arbitrator's denial of other claimed expenses.

Petitioner is awarded prospective care in the form of the right elbow surgery recommended by Dr. Poepping.

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

12/28/17
Date

ICArbDec19(b)

DEC 2 9 2017

Maria Arizpe v. Labor Network
16 WC 16348

18IWCC0555

Summary of Disputed Issues

Petitioner, a bakery line worker, claims repetitive trauma injuries manifesting on April 20, 2016. The disputed issues include accident, earnings, medical expenses, temporary total disability benefits from May 20, 2016 through the hearing of November 16, 2017 and prospective right elbow surgery. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she began working for Respondent, an employment agency, about ten months before April 20, 2016. T. 18. Respondent sent her to Cloverhill Bakery, where she worked on a packing line. T. 18. Her shift lasted twelve hours. T. 18. She spent half of each shift assembling boxes and the other half packing bread into boxes. T. 19-20, 24. She worked five to six days per week. The overtime she performed was mandatory. Any worker who failed to show up for work was assigned a point. A worker who accumulated six points would be fired. T. 24-25.

Petitioner testified she was required to assemble 250 boxes every 10 minutes. T. 27. In order to assemble a box, she had to fold the "ears" or flaps down, turn the box and push the other flaps "inwards with pressure," using both arms. She demonstrated that her arms were bent to a degree between 90 and 120 and internally rotated when she pushed the flaps down. She testified she applied more pressure with her right arm because she is right-handed. T. 27. She testified that box assembly hurt her right arm "more."

Petitioner testified she began experiencing right elbow pain about a month before April 20, 2016. T. 19. On that date, her pain markedly increased because she had to perform "double the work" due to the fact the worker to her left was falling asleep on the job. T. 21-22. Packaged cinnamon rolls were coming down the line at the rate of 500 per minute. T. 22-23. She had to keep her left arm elevated in order to prevent these rolls from piling up and falling to the ground. She had to simultaneously use her right arm to guide the rolls into containers. She testified she packed 24 rolls into each box. The rolls had to be placed so as to display the product name. T. 24.

Petitioner testified she informed her line leader, Paola Gadaramma, that her co-worker was falling asleep but the line did not slow down. Gadaramma was unable to intercede because she could not speak English, the worker's native language. T. 22.

Petitioner testified she first sought medical treatment on April 22, 2016. Silvia, who works in Respondent's office at the bakery, sent her to Physicians Immediate Care on that date.

The electronic records from Physicians Immediate Care reflect Petitioner saw Jack Enter, a certified physician's assistant, on April 22, 2016. The history reflects Petitioner complained of constant, moderate right forearm pain secondary to an injury of April 20, 2016. On right elbow examination, Enter noted tenderness of the lateral epicondyle. He ordered right elbow X-rays, which demonstrated no abnormalities. He injected the lateral epicondyle tendon, prescribed pain medication and released Petitioner to full duty. He directed Petitioner to return to the clinic on April 29, 2016. PX 1.

Petitioner returned to Physicians Immediate Care on April 27, 2016. On this occasion, she saw Dr. Menon. The doctor noted a complaint of persistent right lateral elbow pain despite the injection. He indicated this pain was "worse with movement/after work." On right elbow examination, he noted tenderness of the lateral epicondyle. He prescribed pain medication, an elbow sleeve and four weeks of physical therapy. He released Petitioner to light duty, directing her to avoid strong gripping and limit repetitive motion with the right hand through May 11, 2016. PX 1.

Petitioner testified that Respondent provided her with left-handed work after Dr. Menon imposed restrictions. The left-handed assignment involved working alone throughout a 12-hour shift. T. 32. Trays of packaged bread were brought to her. She had to separate damaged bread from "good" bread and put the "good" bread in another area so that it could be repackaged. T. 29-30. She had to extend her left arm and apply pressure, using her left thumb and first two fingers, to open the plastic packaging. She testified she developed symptoms in her left hand and arm while performing these duties. The pain radiated from the posterior area of her left wrist up her arm to her left shoulder and the left side of her neck. T. 33.

Petitioner underwent an initial physical therapy evaluation at Athletico on May 6, 2016. The evaluating therapist, Daniel Honan, PT, DPT, recorded a history of the April 21, 2016 right elbow injury and noted that Petitioner was currently taking Naproxen and working light duty "using only her L arm." He indicated that Petitioner denied any past history of right elbow problems. PX 2.

Petitioner returned to Physicians Immediate Care on May 7, 2016 and saw a different physician, Dr. Shanahan. The doctor noted that no Spanish-speaking translator was available but that Petitioner could speak "reasonably good English." He indicated that Petitioner was still experiencing right elbow pain and was now complaining of pain in her left hand, left shoulder and the left side of her neck secondary to the restriction of left-handed work. He also noted a complaint of pain and tenderness between the right thumb and index finger and in the right lateral neck area. He dispensed pain medication and directed Petitioner to continue attending therapy. He released her to left-handed work with use of a splint and no lifting over 5 pounds with the left arm. PX 1.

Petitioner testified she continued performing left-handed work, subject to the new restrictions, thereafter. She wore a brace on her right hand during this time. T. 34.

On May 12, 2016, the therapist at AthletiCo noted that Petitioner was still working 12-hour shifts and that she was now experiencing left- as well as right-sided symptoms "due to overuse." PX 2.

On May 13, 2016, Petitioner returned to Physicians Immediate Care and saw Dr. Menon, who recorded the following interval history: "pain in R elbow improved but now with pain of L shoulder and L forearm/wrist. First noticed pain approx. 6 days ago – started because she was using her L arm more. +Dull ache, tingling of L forearm and pain in L shoulder with excessive use." On left upper extremity examination, the doctor noted tenderness of the lateral epicondyle, tenderness of the distal aspect of the left forearm and lateral aspect of the left wrist and positive Finkelstein's testing. He prescribed Prednisone, dispensed a wrist extension control splint and directed Petitioner to continue therapy. He indicated the therapy should address left wrist and shoulder sprains as well as the previously diagnosed right lateral epicondylitis. He directed Petitioner to avoid strong gripping and repetitive motion with either hand and to lift no more than 15 pounds with either arm. PX 1.

Petitioner testified she essentially resumed her original work duties after Dr. Menon modified her restrictions on May 13th. T. 34-35.

On May 16, 2016, the therapist at AthletiCo noted that Dr. Menon wanted him to evaluate Petitioner's left wrist. Three days later, the therapist indicated Petitioner began experiencing left wrist and shoulder pain on May 5, 2016, secondary to "performing all work-related tasks with her L UE since injuring her right elbow on April 21, 2016." He noted that Petitioner was wearing a right elbow strap and a left wrist brace. PX 1, 2. There is no evidence indicating Petitioner returned to AthletiCo after May 19, 2016. A discharge summary dated August 15, 2016 reflects Petitioner attended only four sessions. PX 2.

Petitioner testified the therapy at AthletiCo did not help much. T. 34. On May 20, 2016, she saw Dr. Saldanha, a physician of her own selection. T. 35. The doctor noted a complaint of pain in the neck, arms, elbows and left wrist. He also noted that Petitioner was experiencing numbness in both hands. He indicated that Petitioner reported injuring herself at work while lifting "more boxes than usual." On examination, he noted positive Phalen's testing on the right, positive Tinel's bilaterally and tenderness over the medial and lateral epicondyle, worse on the left. He assessed Petitioner as having "multiple pain generators after overuse injury during work-related activities." He recommended upper extremity EMG/NCV testing, a cervical spine MRI, more therapy and an orthopedic consultation. T. 35-36. PX 6.

On May 24, 2016, Petitioner filed an Application for Adjustment of Claim alleging right arm, left arm and neck injuries of April 20, 2016. Arb Exh 2.

The cervical spine MRI, performed on May 27, 2016, showed 1-2 millimeter posterior annular disc bulges indenting the ventral surfaces of the thecal sac at the C5-C6 and C6-C7 levels. PX 6.

On May 26, 2016, Petitioner saw a chiropractor, Dr. Bialon, at New Life Medical Center. Dr. Bialon noted that Petitioner reported injuring her right elbow at work while packing bread. He also noted that Petitioner was still experiencing right elbow pain and pain in her left wrist, elbow and the left side of her neck. He further noted a history of diabetes controlled by insulin. After examining Petitioner, he recommended a six-week course of chiropractic care, including adjustments, electronic stimulation and ultrasound. PX 3.

Dr. Kandilakis conducted upper extremity EMG/NCV testing on May 27, 2016. He described the results as abnormal, noting "electrodiagnostic evidence suggesting of cervical radiculopathy asymmetrically affecting root levels left C6 and C7 and right C6, to a lesser degree." He also noted findings "highly suggestive of peripheral axonal neuropathy affecting the right and left forearms to hand affecting the right and left median, ulnar and radial sensory nerves." PX 6.

Records in PX 3 reflect Petitioner returned to Dr. Bialon on May 31, June 2 and June 9, 2016. On June 2nd, Dr. Bialon noted that Petitioner was awaiting X-rays and MRI scans. PX 3.

On June 1, 2016, Petitioner saw Dr. Markarian, an orthopedic surgeon affiliated with Orthopedic Associates of Naperville. T. 36. The doctor's lengthy history reflects that Petitioner reported an acute onset of right elbow and shoulder pain on April 20, 2016, while performing a "double" workload on a bread line due to a co-worker "who was sleeping on the job." The history also reflects that, about a

month later, Petitioner developed an acute onset of left hand, wrist and shoulder pain secondary to performing left-handed duty while on restrictions.

Dr. Markarian described Petitioner's past medical history as significant for diabetes.

On initial right elbow examination, Dr. Markarian noted tenderness over the lateral epicondyle, a full range of motion and pain with resisted dorsiflexion at the wrist. On right shoulder examination, he noted pain in the impingement arc, exquisite tenderness over the long head of the biceps and rotator cuff and positive drop-arm testing. On left shoulder examination, he noted similar findings as well as a positive Hawkins maneuver. He further noted tenderness over the first dorsal compartment and positive Finkelstein's testing.

Dr. Markarian diagnosed right rotator cuff and bicipital tendinitis, right lateral epicondylitis, left AC joint arthritis, left rotator cuff and bicipital tendinitis and left De Quervain's tenosynovitis. He prescribed X-rays and MRI scans of the right elbow and both shoulders. He prescribed a thumb spica splint for the left De Quervain's. He directed Petitioner to stay off work. PX 4.

The Windy City bills in PX 10 reflect that Petitioner returned to Dr. Markarian on June 21, 2016, with the doctor dispensing the splint on that date. No dictated office note of June 21, 2016 is in evidence.

Petitioner began a course of care at Physical Therapy Associates on June 22, 2016. The records from this facility identify Drs. Saldanha and Erickson as the prescribing physicians. After the initial evaluation, Petitioner continued attending therapy through January 11, 2017, with the therapist noting virtually no improvement over time. Petitioner testified the therapy did not help much. T. 36.

On June 24, 2016, Dr. Pontinen administered a cervical epidural steroid injection at C5-C6. PX 5.

On June 29, 2016, Dr. Saldanha noted that Petitioner reported some improvement following the neck injection and was continuing to see Dr. Markarian. He recommended a repeat injection and continued therapy. PX 6.

Petitioner underwent MRIs of her left elbow and both shoulders on June 30, 2016. Dr. Kuritza interpreted the shoulder MRIs as showing rotator cuff tendonitis and/or bursitis. He interpreted the left elbow MRI as showing inflammatory changes in the region of the medial epicondyle. He described these changes as "consistent with post-traumatic epicondylitis." PX 4.

On July 8, 2016, Petitioner underwent X-rays of both shoulders and the right elbow. Dr. Kuritza described all these studies as unremarkable. PX 4.

Petitioner returned to Dr. Markarian on July 13, 2016. The doctor reviewed the X-rays and prescribed physical therapy. He directed Petitioner to stay off work and return in four weeks. No additional records from Dr. Markarian are in evidence. PX 4.

On July 15, 2016, Dr. Pontinen administered a second cervical epidural steroid injection at C5-C6. PX 5.

On August 3, 2016, Dr. Saldanha noted that Petitioner felt worse after the second neck injection. He also noted the following:

> "She states that she saw Dr. Markarian and he returned her to work. She states that she was unable to perform her normal work duties and is currently not working."

On re-examination, Dr. Saldanha noted pain with neck movement, with that movement causing "radicular pain down right upper extremity." He also noted positive Tinel's signs bilaterally. He recommended she follow up with the orthopedic specialist, see a spine specialist and continue therapy. He kept Petitioner off work and directed her to return in four weeks. PX 6, 9.

Petitioner saw another orthopedic surgeon, Dr. Poepping of G & T Orthopedics, on August 19, 2016. Petitioner testified she switched to Dr. Poepping because Dr. Markarian left the facility where she had been seeing him. T. 37. A "patient information form" in PX 7 reflects that Petitioner identified Dr. Saldanha as the referring physician.

Dr. Poepping's initial history reflects that Petitioner began developing bilateral hand, wrist and arm pain, as well as neck pain, on April 20, 2016, secondary to packaging duties. He indicated that Petitioner reported some relief from therapy and little relief from two neck injections. He stated that Petitioner was primarily complaining of her right elbow and both hands.

Dr. Poepping described Petitioner's past medical history as significant for diabetes, hypertension and hypercholesterolemia.

On initial examination, Dr. Poepping noted tenderness over the lateral epicondyle on the right, diffuse tenderness to palpation of both wrists with positive Tinel's and Phalen's testing bilaterally, and tenderness over the medial epicondyle on the left.

Dr. Poepping noted he had multiple MRI reports "but no images." He described the EMG results as "somewhat confusing" as they showed "rather diffuse injury to the nerves." He indicated that Petitioner's diabetes "could be contribut[ing] to this to some degree." He saw no need for nerve-related surgery given the "diffuse nature of the problem." Given the duration of Petitioner's right elbow complaints, he recommended a right elbow MRI to evaluate the integrity of the common extensor tendon. He directed Petitioner to remain off work. PX 7.

The right elbow MRI, performed on September 7, 2016, showed "mild soft tissue swelling posteriorly in the region of the olecranon," which Dr. Kuritza viewed as consistent with "post-traumatic soft tissue bruising." PX 8.

Petitioner first saw Dr. Erickson, a board certified neurosurgeon, on September 7, 2016. T. 39. The doctor recorded a history of the right elbow injury and indicated Petitioner complained of neck pain secondary to working on a line with her neck flexed forward, looking down. He reviewed the cervical spine MRI and EMG. He indicated the small herniations shown on the MRI "may or may not be clinically significant." On examination, he noted that neck extension was more restricted than flexion and that Petitioner's left wrist was stiff and tender. He noted no signs of symptom magnification. He ordered upper extremity SSEP testing. PX 6.

On October 5, 2016, Dr. Erickson noted that Petitioner was wearing a splint on her left wrist and was still experiencing pain in her left wrist and arm and the left side of her neck. He indicated that the previous SSEP testing correlated with Petitioner's perceived paresthesia. He attributed Petitioner's neck pain to the "small disc herniations" shown on MRI. He recommended conservative care for that pain "in light of the small size of" the herniations. He continued to keep Petitioner off work. PX 6, 9.

Petitioner returned to Dr. Poepping on October 17, 2016. In his note of that date, the doctor described Petitioner's symptoms as unchanged. He indicated he reviewed the right elbow MRI images. He described the sequences as "not quite optimal for seeing exactly what is going on" but noted some apparent partial-thickness tearing of the common extensor tendon at the lateral epicondyle." He injected the right lateral epicondyle and recommended Petitioner stay off work. He noted she was anticipating spinal surgery. He indicated that, if this surgery "did not work," Petitioner's only real option with respect to the right elbow would be surgical debridement of the common extensor tendon. PX 7.

Petitioner returned to Dr. Pontinen on November 2, 2016. The doctor noted ongoing complaints relative to the neck, shoulders, elbows and wrists. He indicated that Petitioner did not improve following the cervical injections but reported some benefit from the recent right elbow injection. He dispensed Meloxicam, Flexeril and Protonix and directed Petitioner to continue therapy, stay off work and follow up with Drs. Erickson and Poepping. PX 6.

On November 14, 2016, Dr. Poepping noted that the right elbow injection helped only temporarily and that Petitioner was "now back to her baseline." On right elbow re-examination, he noted point tenderness over the lateral epicondyle and pain with resisted wrist extension. He indicated that Petitioner had "maximized her conservative care" and was now interested in right elbow surgery. He directed Petitioner to stay off work while awaiting surgical authorization. PX 7.

On December 14, 2016, Dr. Erickson noted that Petitioner reported increased neck pain with paresthesia affecting all of the fingers of her left hand. The doctor noted she was awaiting elbow surgery. He indicated that Petitioner "seems to have two separate problems." On re-examination, he noted diminished grip strength affecting the left hand. After re-reviewing the cervical spine MRI, he indicated Petitioner might require anterior cervical discectomy and fusion from C5 through C7, "despite the small size of the cervical disc herniations." PX 6.

On December 19, 2016, Dr. Poepping noted that Petitioner's bilateral elbow symptoms were worsening. He indicated he was still awaiting authorization for the previously prescribed right elbow surgery. He recommended that Petitioner stay off work and return in six weeks. PX 7.

Petitioner returned to Dr. Poepping on January 30, 2017. The doctor noted tenderness over the lateral epicondyle on right elbow re-examination. He again recommended surgery but noted an independent medical examination scheduled for later that day. PX 7.

Petitioner testified she submitted to an examination by Dr. Kornblatt in January 2017. The insurance company asked her to see Dr. Kornblatt. The examination lasted "less than five minutes." T. 42.

Dr. Kornblatt's report (RX 1) is dated January 30, 2017. In the report, the doctor indicated he obtained Petitioner's history through an interpreter. He described Petitioner as right-handed. He noted

she worked for "Aryzta Company" from June 20, 2015 through May 20, 2016, making and packing boxes. He indicated that Petitioner completed an incident report on April 20, 2016 complaining of right arm pain which she attributed to "packing and making boxes 12 hours, 6 days per week." He stated that Petitioner denied any specific traumatic event. He noted that Petitioner denied obtaining any relief from two right elbow injections and two cervical spine injections.

Dr. Kornblatt noted that Petitioner complained of constant neck aching, constant right elbow and shoulder pain, some right arm numbness and less significant left elbow and shoulder pain. He described Petitioner's medical history as significant for diabetes and depression. He indicated that Petitioner denied smoking.

On cervical spine examination, Dr. Kornblatt noted diffuse tenderness with palpation of all cervical spinous processes, a functional range of motion in all directions and negative Lhermitte and Spurling's signs. On bilateral shoulder examination, he noted diffuse tenderness with palpation of both shoulders, a moderate limited active range of motion and 5/5 muscle testing. On right elbow examination, he noted diffuse hyperesthesia with light palpation of the right elbow, including the olecranon process, triceps insertion, lateral and medial epicondyles and medial and lateral muscle wads of the forearm. He further noted no muscular atrophy, a full active and passive range of motion and 5/5 muscle strength. On left elbow examination, he noted tenderness over the lateral epicondyle without tenderness posteriorly or medially, no masses, 5/5 strength and a full range of motion.

Dr. Kornblatt diagnosed myofascial pain of the cervical spine, both shoulders and both elbows. He indicated his examination failed to reveal any objective abnormalities referable to these body parts. He described the MRIs as "atraumatic in nature and inconsistent with specific pathology referable to the cervical spine, bilateral shoulders [and] bilateral elbows." He described the medical records he reviewed as "cursory" and "inconsistent with a traumatic event but consistent with myofascial pain complaints." He found no causal relationship between Petitioner's myofascial pain complaints and any specific work event, again noting that Petitioner attributed her symptoms to her general work duties rather than any such event. He did not find Petitioner to be in need of any formal care. Instead, he recommended she perform aerobic exercise and cervical spine and upper extremity strengthening exercises, which she could perform on her own. He found Petitioner capable of unrestricted duty with respect to the cervical spine, both shoulders and both elbows.

At the conclusion of his report, Dr. Kornblatt indicated he would be happy to comment on MRI images and X-rays if these items were forwarded to him. RX 1.

Dr. Kornblatt testified by way of evidence deposition on April 3, 2017. RX 2.

Dr. Kornblatt testified he is board certified in orthopedic surgery. He specializes in spinal disorders. RX 2, pp. 5-6. Kornblatt Dep Exh 1. He examined Petitioner on January 30, 2017 and issued a report concerning his findings. Kornblatt Dep Exh 2. He has no independent recollection of Petitioner. RX 2, p. 8. He also has no recollection of the history Petitioner provided. His report reflects that, via an interpreter, Petitioner complained to him of injuries to her back, arms and shoulders. Petitioner completed a report on April 20, 2016 claiming right upper extremity pain secondary to packing and making boxes 12 hours per day, 6 days per week. In his view, "there was no specific traumatic injury or event." Petitioner underwent care at a company clinic thereafter and continued working until May 20, 2016, by which time she was experiencing bilateral symptoms. She had been off work since May 20th and reported taking care of her two children, ages 8 and 12. She reported undergoing neck and elbow

injections as well as physical therapy. RX 2, pp. 9-10. He diagnosed myofascial pain of the cervical spine, both shoulders and both elbows. He saw no evidence of a cervical spine injury. RX 2, p. 12. Petitioner denied any previous injuries to her hands or elbows. RX 2, p. 12. He would not describe Petitioner's myofascial complaints as "injuries." RX 2, pp. 12-13. Myofascial pain is muscular. People can develop such pain from "normal everyday working" and other activities. RX 2, p. 13. Injection therapy "is very common for myofascial complaints" so it could have been appropriate for Petitioner to undergo neck and shoulder injections. He has no records concerning Petitioner's complaints at the time of these injections so he cannot comment further on the reasonableness or necessity of the injections. RX 2, pp. 13-14. In his opinion, Petitioner required no additional formal care after his examination. He believes it would be beneficial for Petitioner to exercise and intermittently use over the counter non-steroidal anti-inflammatory medication. RX 2, p. 14.

Dr. Kornblatt testified he saw no need for work or activity restrictions. The term "maximum medical improvement" does not apply to Petitioner since that term has to do with a specific disorder or traumatic event. He does not believe Petitioner has permanent impairment. RX 3, p. 15. Petitioner's complaints are not work-related. RX 2, p. 15.

Under cross-examination, Dr. Kornblatt testified he previously performed about 125 spinal surgeries annually. He has begun cutting back. Last year, he performed about 60 surgeries. RX 2, p. 17. During the last 10 years, he has performed only spinal surgery. Prior to that, he performed spinal surgery as well as some fracture work and "a little bit of hand" surgery. RX 2, p. 18. He first obtained board certification in 1987. He was last re-certified in 2007. RX 2, p. 18. If a patient with an upper extremity tendonitis comes to see him, he will treat that patient if he has to but he will not operate. Tendonitis can be treated via medication, injections, therapy or nothing. RX 2, p. 19. He has "no idea" how many patients he saw the previous year. RX 2, p. 19. Last week, he saw more than 20 patients and conducted 8 IMEs. He performs 400 to 420 IMEs annually. He charges $1,000 for the first body part when he conducts an IME and $300 for each additional body part. RX 2, pp. 20-22. Last year, he gave about 40 depositions. He charges $1,000 per hour for deposition time, with a two-hour minimum. His IME practice generates more than $500,000 annually. RX 2, pp. 21-22. He does not know how many patients he treats annually. RX 2, p. 22. Each examinee completes a history form, but not in his presence. RX 2, p. 24. He has no idea whether an interpreter helped Petitioner complete this form. He spent about 10 to 15 minutes examining Petitioner. RX 2, p. 25. He looks at the form the examinee completes but asks no questions about it. RX 2, p. 25.

Dr. Kornblatt testified he reviewed Petitioner's records from Physicians Immediate Care, the various MRI reports and Dr. Erickson's note of October 5, 2016. Based on his report, he did not review any records from Dr. Saldanha or Dr. Markarian. Nor did he review the EMG/NCV study. RX 2, pp. 28-29. If records are not mentioned in the report, he did not review them. RX 2, p. 29. He cannot comment on a "treatment plan" since he saw no such plan in the records he reviewed. RX 2, p. 29. He agreed that a May 13, 2016 note from Physicians Immediate Care documents a prescription for therapy due to right lateral epicondylitis and sprains of the left wrist and shoulder. RX 2, p. 33. During independent medical examinations, he evaluates individuals for different injuries. He is qualified to make opinions concerning conditions that do not involve the spine because of his training and experience in orthopedic surgery, which includes upper and lower extremities. RX 2, p. 37. "Just because you don't operate doesn't mean you're not qualified to diagnose and offer treatment options." RX 2, p. 37.

Petitioner returned to Dr. Erickson on April 12, 2017 and reported no improvement. On re-examination, the doctor noted limited neck extension and poor grip strength of the left hand. After re-reviewing the cervical spine MRI and EMG, and noting that previously prescribed conservative care had not been approved, he recommended an anterior cervical discectomy and fusion from C5 to C7. PX 6.

Petitioner testified she wants to undergo the right elbow surgery recommended by Dr. Poepping. T. 39. She does not want to undergo the cervical spine surgery recommended by Dr. Erickson because her neck "doesn't hurt much." Her concern is her arms, especially the right arm. Her left hand and arm are still symptomatic but her right arm hurts more. T. 40-41.

Petitioner testified she has been off work since May 20, 2016. T. 41. She has received no workers' compensation benefits since that date. T. 41. She has not personally sent her various doctors' "off work" notes to Respondent but she knows the doctors have sent those notes to Respondent via facsimile. The doctors have provided her with documents confirming the facsimile deliveries. T. 41.

Petitioner testified her outstanding medical bills total approximately $80,000. She has two minor children and is not married. She has gotten by financially since May 20, 2016 via food stamps and child support, which she receives from one of her children's fathers. T. 43. She wants to proceed with the right elbow surgery so she can return to work and support her children. T. 43.

Under cross-examination, Petitioner testified she always worked at Cloverhill Bakery after Respondent hired her. Her duties at the bakery did not change between her hire date and the accident. T. 44. She worked in packaging, not on the production line. T. 44. The boxes she assembled were made of cardboard. T. 45. The packages of rolls and bread she placed in the assembled boxes did not weigh more than 5 pounds. T. 45. An interpreter translated for her when she first went to Physicians Immediate Care. T. 45. She was able to relay the details of her injury. She did not withhold any information. T. 45-46. She worked a full shift before going to Physicians Immediate Care. T. 46. An interpreter was available during her examination with Dr. Kornblatt. She relied on the interpreter in explaining her injury to the doctor. T. 46. The doctor asked her "very few questions." T. 47. She completed various tests at his request. She never saw a copy of the report he wrote. T. 47. An interpreter was also available when she went to AthletiCo for therapy. T. 48. When she first saw Dr. Poepping, she told him she has diabetes. T. 49. She sees a female physician, Dr. Wellman, for her diabetes. She took diabetes-related medication during the time she worked for Respondent. She still takes this medication. T. 50. She has never been diagnosed with diabetic neuropathy. T. 51. She has no other health issues for which she is currently undergoing care. T. 51. Dr. Poepping recommended surgery to her when she first saw him. T. 52. The company clinic had previously diagnosed epicondylitis. T. 53-54. She has not seen the reports concerning her elbow and shoulder MRIs. T. 54. She has not looked for work since May 20, 2016. T. 55. She is the primary caretaker for her two children but her mother provides assistance with this. T. 55. She does not take care of most of the home chores. T. 55-56. She drives her children to school. T. 56. The thing that is preventing her from working is her arm pain. Her arm hurts a lot. T. 56. She has not filed another workers' compensation claim. T. 56. She underwent two right elbow injections. The first one was administered at the company clinic. Dr. Poepping administered the second one. T. 57. She last underwent therapy in December 2016. T. 57. She sometimes has to take Tylenol for pain. She did not take Tylenol on the day of the hearing. T. 58. If someone recommended she undergo more right elbow injections, she would not opt for this over surgery. She just wants to have the surgery. T. 58.

On redirect, Petitioner testified her attorneys have explained to her that benefits are being denied based on Dr. Kornblatt's report. T. 59. She has had diabetes for 23 years. The medication she takes for diabetes consists of pills. T. 59. Her diabetes was never an issue, work-wise, before April 20, 2016. T. 60. As of her first visit to Dr. Poepping, she had not undergone any elbow MRIs. Therefore, the doctor could not have recommended elbow surgery at that visit. T. 60. It was after Dr. Poepping reviewed the MRIs that he recommended surgery. T. 60. Her doctors have explained the MRI results to her. Dr. Poepping told her the right elbow MRI showed a tear. T. 61. Gabriel, who works in Respondent's office, told her she had been fired. About a month after the accident, she presented a doctor's note to Gabriel. He then told her not to bring any additional notes to the office because she did not work for Respondent anymore. T. 61-62.

Respondent did not call any witnesses to testify at the hearing. In addition to Dr. Kornblatt's report and deposition transcript, Respondent offered into evidence Petitioner's wage statement covering the period July 2015 through early July 2016. RX 3.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning the duties she performed before and after April 20, 2016 was detailed, believable and unrebutted. Petitioner's account of the "double work" she performed on April 20, 2016 is fully consistent with Dr. Markarian's lengthy history of June 1, 2016. Petitioner's assertion that she frequently worked overtime finds support in the wage statement offered by Respondent. RX 3. Between July 2015 and April 20, 2016, there were many weeks in which Petitioner worked at least 50 hours and some in which she worked 60 or 70. There were only 8 weeks in which she worked no overtime.

Petitioner's testimony that she developed left-sided symptoms after being restricted to left-handed work finds support in the records from Physicians Immediate Care (the facility to which Respondent sent her) and AthletiCo. PX 1-2.

Petitioner testified she did not work after May 20, 2016 but Respondent's wage statement shows she worked 22.75 hours in the last week of May, 8 hours in early June 2016 and 8 hours in early July 2016. RX 3.

Respondent's examiner, Dr. Kornblatt, noted no objective abnormalities on examination but he did not document any symptom magnification. He recommended treatment, albeit in the form of self-care, for Petitioner's myofascial pain complaints. RX 1.

Arbitrator's Conclusions of Law

Did Petitioner establish compensable injuries? Did Petitioner establish causal connection?

Petitioner's claim is hybrid in nature. She alleges she performed "double duty" during her 12-hour shift on April 20, 2016, with that unusual activity aggravating an underlying repetitive trauma right elbow condition for which she had not previously sought care. She further alleges neck, shoulder and left elbow/wrist conditions stemming from the left-handed work she began performing in early May 2016 per restrictions imposed by Dr. Menon of Physicians Immediate Care. PX 1.

The Arbitrator, having considered all of the available evidence, finds that Petitioner established an accident of April 20, 2016, superimposed on a repetitive trauma right elbow condition. In so finding, the Arbitrator relies on Petitioner's credible testimony, the records of Physicians Immediate Care (which document a diagnosis of right lateral epicondylitis), Dr. Markarian's detailed history of June 1, 2016 and Dr. Poepping's records. The Arbitrator further finds that Petitioner established repetitive trauma injuries to her neck, shoulders and left elbow due to overuse stemming from the left-handed work she performed beginning in early May 2016. The Arbitrator finds that Petitioner established causation as to the need for the conservative care she underwent for neck, shoulder, arm and wrist complaints after April 20, 2016 and as to the need for the right elbow surgery recommended by Dr. Poepping. The Arbitrator further finds Petitioner did not establish causation as to any low back condition. It was not until October 2016, after Petitioner began seeing Dr. Poepping, that any provider documented low back pain. PX 7.

The Arbitrator does not find the opinions of Dr. Kornblatt, Respondent's examiner, to be well-supported or persuasive. Dr. Kornblatt is a spine surgeon who, by his own admission, treats upper extremity tendonitis only when he has to. Dr. Kornblatt saw Petitioner once, for fifteen minutes at most (again by his own admission). He reviewed only some of Petitioner's records and none of her radiographic images, although he requested those images in an effort "to be thorough." RX 1. He reviewed the incident report Petitioner completed, which alluded to assembling and packing boxes 12 hours a day, but never addressed causation from a repetitive trauma perspective. Instead, he summarily concluded Petitioner's symptoms were not work-related because she denied a specific trauma.

The Arbitrator notes that Drs. Markarian and Poepping diagnosed the same condition, i.e., right lateral epicondylitis, that providers of Respondent's selection diagnosed at the outset. Dr. Markarian prescribed a right elbow MRI on June 1, 2016 (PX 4) but, unfortunately, that study was not performed until September 7, 2016, after Dr. Poepping also prescribed it. Unlike Dr. Kornblatt, Dr. Poepping reviewed the actual MRI images. He did not leap to the conclusion that Petitioner required surgery, as Respondent attempted to establish during cross-examination. It was only after a repeat right elbow injection failed to provide lasting relief that he concluded Petitioner needed surgery. While he viewed Petitioner's diabetes as contributing, "to some degree," to the abnormalities documented on the EMG/NCV, an employer takes an employee as it finds her. In Illinois, it has long been held that a pre-existing condition does not prevent recovery. See, e.g., Schroeder v. IWCC, 2017 Ill. App. LEXIS 350 (4th Dist. 2017).

What is Petitioner's average weekly wage?

At the hearing, Petitioner claimed earnings of $22,506.25 and an average weekly wage of $486.73 while Respondent claimed an average weekly wage of $400.00. Arb Exh 1. Petitioner maintains her overtime earnings should be included in the calculation but otherwise does not explain exactly how she arrived at a wage of $486.73.

Petitioner testified she began working for Respondent about ten months prior to April 20, 2016. She further testified she worked 12-hour shifts and typically worked five or six days per week. She described her overtime as mandatory. T. 24-25. She did not testify to a specific hourly rate and did not offer any wage-related documents into evidence.

As noted above, Respondent's wage statement (RX 3) fully supports Petitioner's assertion that she frequently worked overtime. Respondent did not offer any evidence contradicting Petitioner's testimony that overtime was required rather than optional.

The wage statement is insufficiently detailed to show the days on which Petitioner worked during each of the 42 weeks she worked preceding April 20, 2016. However, it shows that Petitioner worked at least 40 hours (or, with respect to two weeks in August 2015, very close to 40 hours) in all but 6 of those weeks. The wage statement reflects an hourly rate of $10.00, a total of 1,600.25 regular hours before April 20, 2016 (with three weeks showing 48 regular hours), a total of 412.75 overtime hours before April 20, 2016, no double time hours before April 20, 2016 and gross earnings of $22,163.75 before April 20, 2016.

The Arbitrator finds credible Petitioner's testimony that the overtime she performed was mandatory in nature. In reliance on Freesen v. Industrial Commission, 348 Ill.App.3d 1035 (4th Dist. 2004), the Arbitrator includes the 412.75 hours of overtime earnings, albeit at the straight time rate of $10.00 per hour, in calculating the average weekly wage. The Arbitrator divides $20,130.00 (representing 2,013 hours x 10/hour) by 42 (weeks) to arrive at an average weekly wage of $479.29.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from May 20, 2016 through the hearing of November 16, 2017. Respondent maintains Petitioner is not entitled to any temporary total disability benefits, citing its accident and causation defenses. Arb Exh 1.

The Arbitrator has previously found that Petitioner established causation as to various conditions of ill-being and as to the need for the right elbow surgery recommended by Dr. Poepping.

Petitioner testified she last worked for Respondent on May 20, 2016 (the date she first saw Dr. Saldanha) and has been off work since that date. T. 41. However, Respondent's wage statement (RX 3), while not a model of clarity in terms of dates worked, shows some earnings in late May 2016, early June 2016 and early July 2016. On May 20, 2016, Dr. Saldanha described Petitioner as off work but this is contradicted by RX 3 and subsequent records. On June 1, 2016, Dr. Markarian described Petitioner as being sent back to her regular job as of May 24, 2016. He took her off work. His note concerning the next visit of June 21, 2016 is not in evidence. PX 4. On July 13, 2016, he took Petitioner off work but, on August 3, 2016, Dr. Saldanha noted that, according to Petitioner, Dr. Markarian had released her to work but her attempt to resume her regular job was not successful. Dr. Saldanha took Petitioner off work. PX 6.

On this confusing and incomplete record, the Arbitrator finds that Petitioner was temporarily totally disabled from June 1, 2016 (the date Dr. Markarian took her off work) through July 13, 2016 (the date of the last Dr. Markarian note in evidence, PX 4), with the exception of the two days Petitioner worked for Respondent during this period, per RX 3, and from August 3, 2016 (the date Dr. Saldanha took her off work, following what appears to have been a brief, unsuccessful attempt to resume working per Dr. Markarian) through the hearing of November 16, 2017. There is no evidence indicating any treating physician released Petitioner to work after August 3, 2016. Nor is there any evidence of earnings after August 3, 2016. The Arbitrator views Petitioner's causally related right elbow condition of ill-being as unstable as of the November 16, 2017 hearing, based on Dr. Poepping's surgical recommendation. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). The two intervals of temporary

total disability total 73 1/7 weeks. The Arbitrator awards benefits at the rate of $319.52 per week, having previously found Petitioner's average weekly wage to be $479.29.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of medical expenses totaling $76,681.32 from numerous providers. PX 10.

As a preliminary matter, the Arbitrator notes that none of the expenses claimed by Petitioner relate to treatment rendered after January 30, 2017, the date of Dr. Kornblatt's Section 12 examination. While Dr. Kornblatt did not link Petitioner's symptoms to a work-related event, he acknowledged that those symptoms could be treated via the kind of conservative care, i.e., medication, therapy and/or injections, Petitioner underwent. The Arbitrator further notes that Respondent offered no utilization review evidence.

The Arbitrator awards the claimed $1,535.00 bill from M & R Rudra New Life Medical, subject to the fee schedule. This bill relates to the four visits Petitioner made to Dr. Bialon, a chiropractor, between May 26 and June 9, 2016. The Arbitrator finds it reasonable for Petitioner to have undergone a short course of chiropractic treatment, as recommended by Dr. Saldanha.

The Arbitrator awards the IWP bill in the amount of $987.07 relating to medication prescribed by Dr. Pontinen on October 6, 2016.

The claimed $11,834.00 bill from Edgebrook Open MRI includes travel expenses totaling $750.00. The Arbitrator declines to award these expenses. Petitioner offered no evidence explaining why she required transportation. The Arbitrator awards the balance of $11,084.00, subject to the fee schedule. The Arbitrator finds it reasonable for Petitioner to have undergone MRIs of her shoulders, elbows and cervical spine, in light of her complaints and lack of response to conservative measures.

The Arbitrator awards the $1,870.00 bill from G & T Orthopedics, subject to the fee schedule. This bill relates to elbow treatment rendered by Dr. Poepping between August 19, 2016 and January 30, 2017. Respondent's examiner, Dr. Kornblatt, expressed no knowledge, let alone criticism, of the care rendered by Dr. Poepping. RX 1-2.

The Arbitrator awards the $2,759.86 bill from Midwest Anesthesia & Pain Specialists, subject to the fee schedule. This bill relates to Petitioner's visits to Drs. Saldanha and Pontinen between June 24, 2016 and November 2, 2016.

The Arbitrator awards the $5,819.30 bill from Windy City RX. This bill relates to medication prescribed by Drs. Saldanha and Markarian between May 20, 2016 and November 2, 2016.

The Arbitrator awards the $1,736.00 bill from Illinois Anesthesia Specialists, subject to the fee schedule. This bill relates to anesthesia administered in connection with the cervical spine injections of June 24 and July 15, 2016.

The claimed $13,140.00 bill from Windy City Medical Specialists covers services provided between May 20, 2016 (the date of Petitioner's first visit to Dr. Saldanha) and December 19, 2016. PX 10. It includes several non-emergency transportation charges as well as charges relating to a

Vascutherm home rental unit (dispensed on May 26, 2016), a pre-fabricated thumb spica splint (prescribed by Dr. Markarian in June 2016) and a cervical collar (dispensed on December 19, 2016). The Arbitrator declines to award the transportation, Vascutherm- and collar-related charges. Petitioner did not establish the need for non-emergency transportation and did not mention the Vascutherm unit or cervical collar at any point during her testimony. The bill identifies Dr. Saldanha as the physician prescribing the Vascutherm unit but his records (PX 6) do not mention this prescription. The bill identifies Dr. Erickson as the physician prescribing the cervical collar but his note of December 14, 2016 (PX 6) does not mention this prescription. Of the claimed $13,140.00, the Arbitrator awards only the $250.00 relating to the splint dispensed by Dr. Markarian on June 21, 2016.

The Arbitrator awards the $28,870.00 bill from Physical Therapy Associates, subject to the fee schedule. This bill relates to the treatment (therapy, ultrasound, EMS/TENS) Petitioner underwent between June 22, 2016 and January 11, 2017, at the direction of Drs. Saldanha and Pontinen.

The Arbitrator awards the $10,000.00 bill from Hyde Park Same Day Surgicenter, subject to the fee schedule. This bill sets forth facility charges relating to the cervical spine injections administered by Dr. Pontinen on June 24 and July 15, 2016. The Arbitrator finds it reasonable for Petitioner to have undergone two such injections, given her persistent neck complaints. Respondent's examiner, Dr. Kornblatt, did not link Petitioner's neck symptoms to any specific work trauma but he acknowledged such symptoms could be treated via injections.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found that Petitioner established causation as to a right elbow condition and as to the need for the right elbow surgery recommended by Dr. Poepping. The Arbitrator awards prospective care in the form of this surgery.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL BOYER,

Petitioner,

vs. NO: 04 WC 32025

AMICO METALS/ALABAMA METALS,

Respondent.

ORDER

Petition for Attorneys' Fees pursuant to Section 16 of the Illinois Workers' Compensation Act having been filed by attorney Steven A. Globis of the law firm of Marszalek & Marszalek, and due notice having been given, this cause coming before Commissioner Charles DeVriendt for hearing on October 20, 2017 in New Lenox, Illinois. Petitioner's former counsel was present. Petitioner's subsequent counsel, Mr. David Feuer of the law firm of Goldstein, Fishman, Bender & Romanoff, was not present despite receiving notice of hearing via certified mail. The Commission having jurisdiction over the persons and subject matter and after considering the entire record, grants the Petition for Fees as delineated herein for the reasons set forth below.

Statement of Facts

On or about June 24, 2004 Petitioner retained the law firm of Marszalek & Marszalek to represent him regarding his workers' compensation claim against Respondent, Amico Metals/Alabama Metals. An Applications for Adjustment of Claim was filed on Petitioner's behalf relating to an injury sustained on June 3, 2004. Petitioner executed a contingency fee agreement for 20% of any disputed amounts secured by settlement. EX2.

To that end, the firm of Marszalek & Marszalek undertook representation of Petitioner. On or about September 24, 2007, Petitioner terminated his relationship with Marszalek &

Marszalek. Prior to the termination, as evidenced by the affidavit dated October 18, 2017 and sworn to by James J. Marszalek, approximately twenty-five hours of legal work was expended on the representation of Petitioner including meetings, telephone conferences, drafting of correspondences, and appearances at the Illinois Workers' Compensation Commission (IWCC). No documentation regarding the written correspondences was provided. EX4. Marszalek & Marszalek also alleged expending costs in the amount of $795.00, but no documentation of the same was provided. EX1. In reviewing the docketing system of the IWCC, the Commission takes note of Petitions filed on behalf of Petitioner on September 30, 2005, May 17, 2007, and June 25, 2007.

Following the termination of Marszalek & Marszalek, Petitioner retained the services of Mr. David Feuer of the law firm of Goldstein, Fishman, Bender & Romanoff. The matter proceeded to hearing on July 29, 2009 resulting in an award of 8% loss use of the right arm under Section 8(e) of the Act. The Commission affirmed and adopted the arbitrator's decision on January 7, 2011. Further appeals were subsequently filed on behalf of Petitioner, and the appellate court entered its Rule 23 Order on April 27, 2015 affirming the decision of the Commission.

Conclusions of Law

An attorney who represents a client pursuant to a contingent fee agreement and is thereafter discharged by a client with or without cause is entitled to be paid for services rendered prior to the termination on a *quantum meruit* basis. *Rhoades v. Norfolk and Western Railway Company*, 78 Ill. 2d 217, 399 N.E.2d 969 (1979). "Moreover, the time and labor required in a case is but one factor to be considered in determining a reasonable attorney fee under the doctrine of *quantum meruit*. The other factors are the attorney's skill and standing, the nature of the cause and the novelty and difficulty of the subject matter, the degree and responsibility in managing the cause, the usual and customary charge in the community and the benefits resulting to the client. [citation omitted]." *Johns v. Klecan*, 198 Ill. App. 3d 1013, 1019, 556 N.E.2d 689 (1990).

Reviewing the record as a whole in the context of the standards established by *Johns*, the Commission concludes Marszalek & Marszalek is entitled to a fee in the amount of $450.00 given its efforts over its approximate three-year period of representing Petitioner. Marszalek & Marszalek alleges it spent approximately twenty-five hours in representing Petitioner but provided no documentation supporting the same outside the affidavit of October 18, 2017. Certainly an attorney who represents a client on a contingency fee basis is not held to the same standard of specificity as an hourly fee attorney, but some documentation is required. Based upon the affidavit as well as the Commission's docketing system which evidences Marszalek & Marszalek prepared and filed motions and/or petitions on Petitioner's behalf on three separate occasions, it is determined three (3) hours of work was expended.

As for the remaining factors established by *Johns*, Marszalek & Marszalek presented little to no evidence in support of the same. The affidavit alleges a usual and customary hourly rate to equal $150.00 which is not challenged and thereby adopted by the Commission.

IT IS HEREBY ORDERED BY THE COMMISSION that Goldstein, Fishman, Bender & Romanoff shall pay the sum of $450.00 to Marszalek & Marszalek pursuant to Sections 16 and 16a of the Act.

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $550.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 10 2018
R102017
LEC
43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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 Choose reason	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify: Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID TADLA,

Petitioner,

18IWCC0556

vs.

NO: 15 WC 17635

UNITED PARCEL SERVICE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent disability, which was also the only issue at arbitration, 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 & Conclusions of Law

1. Petitioner testified that on April 29, 2015, he had been a union feeder driver for Respondent for approximately 30 to 32 years. His job entails moving trailers between Respondent facilities or within Respondent's property. He was right-handed and the tractors he drove were "basically manual" requiring shifting the nine-gear transmission with the right hand. He had to climb three stairs to get into the cab. He had to lift items and had to connect air hoses and cords from the tractors to the trailers. He would reach with his right arm to make those connections. To release the chassis from the trailer he had to pull the pin on the 5th wheel. Some of the pins are more difficult to pull than others. He would have to fully extend his right arm. He also had to turn handles either clockwise or counterclockwise.

2. On April 29, 2015, Petitioner injured his right shoulder while attaching a trailer to a tractor. It was determined to have aggravated his pre-existing severe arthritis of the acromioclavicular joint. On November 24, 2015, Dr. Chudik, an orthopedic surgeon from Hinsdale Orthopedics, performed right shoulder arthroplasty, cemented polyethylene glenoid, uncemented humeral stem, rotator cuff repair, and biceps tenodesis for glenohumeral arthritis, rotator cuff tear, and partial biceps rupture and instability.

3. On April 27, 2016, Petitioner had a functional capacity evaluation ("FCE"). His job was deemed to be at a medium physical demand level. The FCE was deemed valid and Petitioner demonstrated the ability to function at a heavy physical demand level.

4. On May 4, 2016, Petitioner reported some soreness after the FCE. Dr. Chudik declared him at maximum medical improvement, released him to work as of May 9th, and noted he would continue his home exercise program. Petitioner would follow up in six months.

5. Petitioner returned on November 21, 2016 and reported doing well and was able to complete activities of daily living as well as his work activities. His strength and range of motion were within normal limits. Dr. Chudik noted that overall Petitioner had recovered very well. He would continue his home exercise program and return for follow up annually.

6. On June 14, 2017, Petitioner reported he was doing well overall and able to perform activities of daily living as well as his work activities. However, two weeks earlier, he noticed pain while cranking the legs on a trailer. He had some pain and soreness since. X-rays were normal. Dr. Chudik continued Petitioners full-duty status but advised him to avoid aggravating activities as much as possible. If the pain persisted, they would consider restrictions.

7. Dr. Bush-Joseph, an orthopedic surgeon with Midwest Orthopedics at Rush, testified by deposition on January 31, 2018. At Respondent's request he performed two Section 12 examinations on Petitioner, one on September 16, 2015 and one on February 15, 2017.

8. Dr. Bush-Joseph testified he was certified to perform impairment rating pursuant to AMA Guides. He performs one or two such ratings a month, the majority for respondents. He reviewed Dr. Chudik's operative report and took x-rays. They showed a well-aligned, well-fixed total shoulder replacement with no evidence of loosening. Petitioner had mild residual deltoid atrophy and some weakness of the girdle-muscle strength. Range of Motion was within normal limits. He rated Petitioner's impairment at 20% of the right arm and 12% of the person-as-a-whole.

9. On cross examination, Dr. Bush-Joseph testified he performs shoulder replacement surgery, of which there are several types. He agreed with Dr. Chudik's choice of anatomic shoulder replacement surgery. In such surgery, the head of Petitioner's humerus was removed and replaced with a transplant in the surgery. In addition, the supraspinatus muscle was detached and reattached to the upper part of the humerus.

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10. Dr. Bush-Joseph noted that patients with this type of surgery reach maximum medical improvement and will be able to perform "higher-end functions" within six to eight months of surgery. They generally get significant pain relief from the surgery, but still have some functional limitation of the arm, though some experience near normal function. Greater stress on the prosthetic shoulder can endanger its longevity. He would advise Petitioner to avoid heavy weightlifting and regular lifting greater than 30 to 35 lbs. He agreed that the FCE noted Petitioner's ability to lift occasionally 30.6 lbs overhead with this right arm and 32.8 with his left, which was consistent with his findings.

11. Dr. Bush-Joseph also noted that during his examination, Petitioner had pain around his shoulder area. Dr. Bush-Joseph believed his symptoms were consistent with objective findings and related to his work injury. He agreed that the general class of Petitioner's diagnosis in the AMA guides had a range of impairment between 20% and 25% of the arm. He modified the grade based on the positioning of the prosthesis, the arthritic nature of the joint, and Petitioner's subjective complaints while working. Normally, patient with shoulder arthroplasty are evaluated annually to assess possible loosening.

12. On redirect examination, Dr. Bush-Joseph testified that Petitioner's symptoms were consistent with those of other patients with shoulder arthroplasty. Petitioner's response to surgery was "median." It would be speculation for him to opine about the probability of future revision.

13. At arbitration Petitioner testified that his "pain increases as the week goes along, especially on the manual transmissions." The pain is in the front and the top of his shoulder. He also had some pain in the right shoulder-blade area. As the day goes on his shoulder gets stiff and there is more pain. It subsides over the weekend. He has to use his left arm more for work activities. He has to crank 10 to 15 times to crank the landing gear up and down. It hurts. Sometimes he needs help because he lacks strength in his right arm. He never asked for help prior to the accident. Now he needed assistance to perform his job. He might be driving the tractors five to nine hours a day.

14. Petitioner also testified that he no longer bowls or plays golf. He used to go backpacking but can no longer carry the canoe over his head. He can still paint walls, but his wife has to paint the ceiling, because that involves too much extension overhead. He finds that embarrassing. He also has difficulty pulling the cord to start the lawn mower. About all he does for his pain was take Advil and he tries to stretch during work. That was something he was taught in physical therapy.

15. On cross examination, Petitioner estimated that he was about 10 inches to a foot away from the manual transmission. He does not have to change positions to reach the shifter. He has difficulty moving the shifter on certain tractors. He has to change tractors often. He still uses his right hand to release the tractor. He uses both hands to lift and move dollies. He still uses his right arm as he did prior to the accident, but "very gingerly." He has sufficient seniority that he does not have to load trailers. He agreed that he has the option of using low gear or high gear to raise the landing gear, but sometimes he cannot move it even in low gear and needs assistance because of pain and lack of strength.

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16. Petitioner also testified he can still operate the mower and leaf-blower, but it hurts. He used to golf once every week in the summer. In his younger days he bowled in a league. But after the accident, he noticed that he would get pain after three or four frames while bowling with his family. Prior to the accident he backpacked three to four times a year. He can still carry a backpack but not the 70-pound canoe.

17. Petitioner explained that he returned to his regular job after Dr. Chudik released him. He works pretty much the same number of hours. He still works overtime; it is required. The surgery allowed him to return to work, but his shoulder was not as it was pre-accident. He continued to work after his release, even though he continued to see Dr. Chudik.

18. On redirect examination, Petitioner testified that prior to his accident he did not have pain operating the manual transmissions, even the difficult ones. He releases the pins with the right hand, because that is the proper way; the way it is made. Since the accident, he played golf once and stopped after nine holes. He had difficulty bringing his arms back to swing.

The Arbitrator awarded Petitioner 162.5 weeks of permanent partial disability benefits representing loss of 32.5% of the person-as-a-whole. The Arbitrator noted that he gave little weight to Dr. Bush-Joseph's AMA impairment rating because he testified there was a subjective component to the rating. He gave great weight to Petitioner's occupation which involved heavy physical demand and repetitive use of his right arm and shoulder. He also found his age of 59 increased his level of disability. Finally, he gave great weight to potential earning loss because he testified he had difficulty at work and Dr. Chudik advised him to limit activities.

In assessing the nature and extent of Petitioner's permanent partial disability, the Commission notes that on November 21, 2017, Petitioner reported he was doing well, able to perform his activities of daily living as well as his work activities, and Dr. Chudik noted that his range of motion and strength were within normal limits. The FCE, performed about five months after surgery, indicated Petitioner could function at a heavy physical demand level. He returned to a labor-intensive job, within six months of surgery without restrictions. Dr. Bush-Joseph noted that Petitioner's limitations were normal for a patient who had the surgery Petitioner had.

In looking at the record in its entirety, the Commission concludes that the Arbitrator placed too little weight on Dr. Bush-Joseph's AMA impairment rating and placed too much ("great") weight on his age and possible loss of earning potential as factors to increase the disability award. Specifically, the Commission notes that Petitioner's age, 59 at the time of the accident, may actually be used as a factor to decrease disability because he had a limited expected future working life in which do deal with the disability. In addition, there was no evidence of potential loss of income and his ability to return to his labor-intensive job at the age of 60 would seem to make the inability to continue his job until a normal retirement age less likely. Petitioner testified as to some continuing limitations. Nevertheless, in looking at the record in its entirety, the Commission finds a permanent partial disability award of loss of 25% of the person-as-a-whole is appropriate and modifies the Decision of the Arbitrator accordingly.

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IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,336.34 per week for a period of 49&3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained to the right shoulder caused a 25% loss of the use of the person-as-a-whole.

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

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

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

DATED: SEP 10 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-8/30/18
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0556

TADLA, DAVID L
Employee/Petitioner

Case# **15WC017635**

UNITED PARCEL SERVICE
Employer/Respondent

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
NANCY D WILENSKY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David L. Tadla Case # **15 WC 17635**
Employee/Petitioner

v.

United Parcel Service
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **March 19, 2018**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 4/29/2015, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$92,193.60** ; the average weekly wage was **$2,004.21**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$66,043.50** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$66,043.50**.

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

ORDER

- Respondent shall pay Petitioner temporary total disability benefits in the amount of **$1,336.14**/week for **49-3/7** weeks, for the period of **5/29/2015 through 5/8/2016**, which is the period of temporary total disability for which compensation is due. The parties stipulated that there was no over or underpayment of benefits.

- Respondent shall pay Petitioner the sum of **$735.37**/week for a further period of **162.5** weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained to the right shoulder caused a **32.5%** loss of use of the person as a whole.

- Respondent shall pay Petitioner the compensation accrued from **4/29/2015** through **3/19/2018** and shall pay the remainder of the award, if any in weekly payments.

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

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

David A. Kane Signature of Arbitrator

March 28, 2018

Date

Arbitrator Decision Paragraphs

APR 2 - 2018

David L. Tadla
Case Number: 15 WC 17635
Date of Accident: 4/29/2015

18IWCC0556

RIDER TO THE ARBITRATION DECISION

I. INTRODUCTION

Evidence in the above-captioned claim was presented to Arbitrator Kane on March 19, 2018. On that date, the Arbitrator heard the testimony of Petitioner. The Arbitrator also received into evidence various exhibits, which included: 1) medical records from multiple providers; 2) physical therapy records; 3) diagnostic study reports; 4) operative report dated November 24, 2016; 5) FCE report dated April 27, 2016; 6) Section 12 reports of Dr. Bush-Joseph; and 7) transcript of the evidence deposition of Dr. Bush Joseph. The Arbitrator is considering the disputed issues of medical causation and nature and extent of the injury.

Before making conclusions of law in connection with this case, the Arbitrator makes the following findings of fact:

II. FINDINGS OF FACT

Petitioner testified before the Arbitrator on March 19, 2018. The Arbitrator finds that Petitioner's testimony was credible. The Arbitrator also finds that Petitioner's testimony was consistent with the histories, treatment and objective findings documented in the medical records, which were offered into evidence at the time of the hearing. Specifically, the histories regarding the accident were consistent throughout Petitioner's medical treatment. Further, Petitioner's testimony was unrebutted.

A. Work History and Background

Petitioner testified that he was employed by Respondent as a feeder driver on April 29, 2015. Petitioner was a member of the Teamsters union, Local 705. He had been a member of the Local 705 for approximately 32 years as of April 29, 2015. Petitioner is right handed.

Petitioner testified regarding his job duties for Respondent as a feeder driver. Petitioner drove a tractor trailer. Petitioner moved empty trailers from Respondent's facility to other facilities, customer's facilities and train yards to refill them. He lifted and carried fifty (50) to seventy (70) pounds. Petitioner lifted dollies which weighed seventy (70) pounds. Petitioner worked ten (10) hours per day, five (5) days per week. Petitioner grasped and reached as part of his job duties for Respondent. The tractor trailer had a manual transmission. Petitioner used his right hand to constantly shift gears while driving. The transmission is a nine (9) speed shift. Petitioner operated the manual transmission with his right hand. He bent his right elbow 90 degrees and pulled the shifting handle backwards and forward. He also connected airs hoses and lift cords to the tractor trailer. To connect the cords, Petitioner used his right hand. He had to extend his right arm and climb on the tractor trailer to connect the cords. Petitioner released chassis from tractors and raised and lowered landing gears. Petitioner pulled a pin with his right hand to release the tractor trailer. He had to squat and reach under the mud flap on the tractor to pull out the pin that released the chassis. Petitioner also cranked handles to raise and lower the landing gear. Petitioner used both hands to use the crank. Petitioner performed pushing and pulling. Petitioner climbed up three (3) steps to the cab of the tractor trailer.

B. Prior Medical Treatment

Petitioner testified that prior to April 29, 2015 he had not sustained any accidents of injuries to his right shoulder. Further, prior to April 29, 2015 Petitioner had not received any medical treatment for the right shoulder.

C. Work-Related Accident of April 29, 2015

Petitioner was performing his job duties for Respondent on April 29, 2015. Petitioner was working at the Burlington Northern Santa Fe Train Yard. Petitioner was picking up a container. Petitioner pulled a tandem pin from the tractor-trailer with his right arm. The pin was eighteen (18) to twenty (20) inches long. To grab the pin, Petitioner reached underneath the tires of the truck. When he pull the pin, it did not move. As Petitioner was pulling on the pin, he felt a pop in his right shoulder and immediate pain. Petitioner reported the accident to his supervisor.

D. Medical Treatment

Following the accident of April 29, 2015, Petitioner sought medical treatment. Petitioner was initially examined at Midwest Orthopedic at Rush- Occupational Health Clinic on April 29, 2015. (PX 1). Petitioner presented with pain in the right shoulder after attempting to release a pin from a rear trailer wheel. (PX 1). X-rays of the right shoulder revealed severe degenerative changes at the glenohumeral joint. (PX 1).

Petitioner was examined at Midwest Orthopedics at Rush on April 30, 2015. (PX 1). Physical therapy was ordered and Petitioner was released to return to work with restrictions. (PX 1). Petitioner's work restrictions were accommodated from April 30, 2015 through May 28, 2015. Following May 29, 2015, Respondent did not provide Petitioner with accommodated work.

On May 8, 2015, the physician at Midwest Orthopedics at Rush recommended medication and work restrictions. (PX 1). Petitioner participated in physical therapy for the right shoulder at Perform Physical Therapy from May 12, 2015 through June 15, 2015. (PX 3).

Petitioner continued to have follow up appointments at Midwest Orthopedics at Rush. (PX 1). On May 27, 2015, Petitioner was referred to a sports medicine physician and an MRI for the right shoulder was recommended. (PX 1).

Petitioner was examined by Dr. Chudik on June 1, 2015. (PX 2). Dr. Chudik recommended an MRI and that Petitioner remain off work. (PX 2). Petitioner underwent the MRI study at Hinsdale Orthopedic on June 11, 2015. (PX 4). The MRI revealed advanced glenohumeral arthritis, moderate supraspinatus and moderate to severe infraspinatus tendinosis, suspicion of full-thickness tear involving the subscapulartistendon superior fibers, long head biceps tendon medial subluxation from bicipital groove, diffuse labral degeneration, moderate glenohumeral joint effusion and moderate acromioclavicular joint degenerative changes. (PX 4).

On June 15, 2015, Dr. Chudik recommended conservative treatment, including physical therapy. (PX 2). He also discussed the possibility of a shoulder replacement. (PX 2). At the recommendation of Dr. Chudik, Petitioner participated in physical therapy at ATI Physical Therapy. (PX 6). On August 12, 2015, Dr Chudik recommended that Petitioner undergo a right shoulder arthroplasty. (PX 2).

Petitioner underwent the recommended surgery on November 24, 2015 at Hinsdale Hospital. (PX 5). Dr. Chudik performed a right shoulder arthroplasty, right rotator cuff repair and right biceps tenodesis. (PX 5). The post-operative diagnosis was right shoulder glenohumeral arthritis,

right subscapularis rotator cuff tear, right biceps instability and partial rupture. (PX 5).

Petitioner remained under the post-operative care of Dr. Chudik. (PX 2). Post-operative care included office visits, physical therapy and work conditioning. (PX 2); (PX 6). On April 13, 2016, Dr. Chudik recommended that Petitioner undergo an FCE. (PX 2). Petitioner underwent the recommended FCE on April 27, 2016 at ATI Physical Therapy. (PX 7). The FCE was valid and set forth that Petitioner met the physical requirements of his job. (PX 7).

Petitioner was examined by Dr. Chudik on November 21, 2016. (PX 2). Dr. Chudik noted that Petitioner experienced aching and soreness with repetitive activities. (PX 2). Dr. Chudik recommended that Petitioner participate in a home exercise program and follow up annually for x-rays. (PX 2).

Petitioner was last examined by Dr. Chudik on June 14, 2017. (PX 2). Petitioner experienced right shoulder pain and soreness. (PX 2). Petitioner experienced pain and soreness with cranking the legs up and down on the trailer, manually shifting the vehicle and releasing the fifth wheel on the dolly. (PX 2). Dr. Chudik documented that Petitioner wanted to continue working; however, if the pain and soreness persisted than he would consider work restrictions in the future. (PX 2). He set forth an impression of status post right shoulder replacement and status post chronic rotator cuff repair and biceps tenodesis. (PX 2). Petitioner testified that Dr. Chudik advised him to avoid activities that aggravate his right shoulder.

E. Medical Opinions of Dr. Bush-Joseph, Respondent's Section 12 Physician

At the request of Respondent, Petitioner was examined by Dr. Bush-Joseph pursuant to Section 12. Dr. Bush-Joseph examined Petitioner on September 16, 2015. (RX 2). Dr. Bush-Joseph set forth a diagnosis of end stage glenohumeral arthritis. (RX 2). Dr. Bush-Joseph stated that the subjective complaints are consistent with the objective findings, including the MRI findings, examination findings and associated atrophy. (RX 2). Dr. Bush- Joseph did not find any evidence of symptom exaggeration. (RX 2). Dr. Bush-Joseph opined that Petitioner sustained an exacerbation or acceleration of the arthritic condition of his right shoulder as a result of the work-related accident of April 29, 2015. (RX 2). He stated that the work-related accident resulted in the need for a total shoulder replacement and an aggravation of the end stage glenohumeral arthritis and resulted in the current pain, disability and declining function. (RX 2).

Dr. Bush-Joseph performed an impairment rating on February 15, 2017. (RX 3). On physical examination of the right shoulder, Petitioner had forward elevation of 160, abduction of 155, abduction external rotation of 90 and abduction internal rotation of 20 degrees. (RX 3). Petitioner experienced pain and weakness in his right shoulder with forward elevation and abduction. (RX 3). Dr. Bush-Joseph set forth an impression of status post total shoulder replacement with good outcome and residual pain. (RX 3). Dr. Bush-Joseph found that Petitioner had reached maximum medical improvement. (RX 3). He noted that a home exercise program and use of over-the-counter medication was appropriate and reasonable. (RX 3). Dr. Bush-Joseph set forth an AMA Impairment Rating of 20% upper extremity impairment or 12% impairment to the whole person. (RX 3).

The evidence deposition of Dr. Bush-Joseph was completed on January 31, 2018. (RX 1). Dr. Bush-Joseph testified that the work-related accident was an acceleration and aggravation of the pre-existing arthritic condition. (RX 1 at 9). Dr. Bush-Joseph testified that the work-related accident exacerbated and accelerated the arthritis condition in the right shoulder. (RX 1 at 14). He explained that pulling the tandem pin aggravated or accelerated the condition. (RX 1 at 15). Dr. Bush-Joseph testified that Petitioner had pain weakened to both forward elevation and abduction which was related to the total shoulder replacement. (RX 1 at 17-18).

On February 15, 2017, Dr. Bush-Joseph took x-rays of Petitioner's right shoulder. (RX 1 at 11). The x-rays revealed evidence of a well-aligned, well-fixed total shoulder replacement without evidence of loosening. (RX 1 at 11). On physical examination, Dr. Bush-Joseph found mild residual deltoid atrophy and weakness of the shoulder girdle muscle strength. (RX 1 at 11). Petitioner had mild pain related weakness with forward elevation and abduction. (RX 1 at 11).

Dr. Bush-Joseph found that Petitioner had reached maximum medical improvement. (RX 1 at 12). Dr. Bush-Joseph testified that the impairment rating was 20% upper extremity impairment or 12% whole person impairment. (RX 1 at 12). Dr. Bush-Joseph testified that with an impairment rating, the range for a shoulder replacement is between 20 to 25% upper extremity impairment regardless of further analysis. (RX 1 at 31). He explained that there is a subjective component to the AMA Impairment analysis. (RX 1 at 32). Dr. Bush-Joseph testified that impairment is different than disability. (RX 1 at 34).

Dr. Bush-Joseph described the shoulder replacement surgery that Petitioner underwent. (RX 1 at 19). Petitioner underwent an anatomic

shoulder replacement. (RX 1 at 19). The surgery repaired the glenohumeral joint with a prosthesis. (RX 1 at 20). Part of the rotator cuff was removed and repaired and the humerus was removed. (RX 1 at 20). The humeral head was replaced and the subscapularis was removed and reattached to the humerus using sutures. (RX 1 at 20-21). Dr. Bush-Joseph testified that the amount of strain placed on the joint would affect the length of time that the replacement could last. (RX 1 at 21). Dr. Bush-Joseph recommended that Petitioner avoid heavy lifting. (RX 1 at 24). He testified that lifting greater than thirty (30) to 35 pounds on a regular basis would place the shoulder at an increased risk for future problems. (RX 1 at 24). Dr. Bush-Joseph testified that he would recommend annual follow up visits and x-rays. (RX 1 at 33).

Dr. Bush-Joseph testified that Petitioner experienced pain around the front and lateral side of the shoulder area. (RX 1 at 28). Petitioner also experienced shoulder blade pain. (RX 1 at 28). Dr. Bush-Joseph testified that the subjective complaints that Petitioner was experiencing were consistent with the objective findings. (RX 1 at 29). He also testified that the subjective complaints were directly related to the work-related condition. (RX 1 at 29). Specifically, Dr. Bush-Joseph testified that Petitioner's current symptoms were related to the work-related injury, subsequent treatment and the outcome of the treatment. (RX 1 at 29).

F. Current Subjective Complaints

Petitioner returned to work for Respondent on May 9, 2016. Petitioner testified that he experienced pain in his right shoulder while performing his job duties for Respondent. Petitioner testified that he relies on his left arm more than his right while performing work. He also requests assistance with some activities, such as operating the crank. Prior to April 29, 2015,

Petitioner did not require assistance performing his job duties. Petitioner experiences pain in his right shoulder when he uses the manual transmission. Petitioner has difficulty releasing the pin and using the crank. Petitioner seeks assistance with moving dollies, sliding tandems and cranking to lower the landing gear. Petitioner experiences pain, stiffness and loss of range of motion in his right shoulder. Petitioner takes Advil for the pain.

Petitioner testified that since the work-related accident of April 29, 2015 he has not been able to golf. Further, he cannot go bowling or backpacking. Petitioner experienced pain in his right shoulder when he tried golfing or bowling. Petitioner used to bowl and golf prior to the work-related accident of April 20, 2015. He also went backpacking and carried a canoe which weighed approximately seventy (70) pounds. Since April 29, 2015, Petitioner has not been able to pain the ceiling in his house or start the lawn mower. Petitioner testified that he has not had any new accidents or injuries since April 29, 2015.

III. CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions:

The Arbitrator concludes that Petitioner's current condition of ill-being in connection with his right shoulder, including an aggravation of end stage glenohumeral arthritis requiring a total shoulder replacement, were causally connected to the work-related accident of April 29, 2015. Specifically, the work-related accident of April 29, 2015 aggravated the glenohumeral arthritis resulting in the need for a total shoulder replacement. The Arbitrator relies on the credible and unrebutted testimony of Petitioner, the

medical records admitted into evidence and the medical opinions of Dr. Bush-Joseph, Respondent's Section 12 physician. Since Respondent's Section 12 physician, Dr. Bush-Joseph, testified that the work-related accident of April 29, 2015 aggravated Petitioner's end stage glenohumeral arthritis and caused the need for the total shoulder replacement, the Arbitrator finds that Respondent has no evidence to dispute a finding of causation. Accordingly, based on the opinions of Dr. Bush-Joseph, the Arbitrator finds that Petitioner's current condition of ill-being in connection with the right shoulder was aggravated as a result of the work-related accident of April 29, 2015. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003) (holding that the accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being").

The Arbitrator further concludes that Petitioner has established that his current condition of ill-being in connection with his right shoulder is causally related to the work-related accident of April 29, 2015 through the "chain of events" analysis. Proof of prior good health and change immediately following and continuing after an injury may establish that the impaired condition was due to injury. *Ill. Power Co. v. Indus. Com'n*, 176 Ill.App.3d 317, 530 N.E.2d 617 (4th Dist. 1988).

The Arbitrator concludes that based on the medical evidence and unrebutted testimony of Petitioner, Petitioner was not under active medical treatment, did not experience any symptoms in his right shoulder and was able to work for Respondent prior to April 29, 2015. However, following the work-related accident of April 29, 2015, Petitioner received consistent symptoms and medical treatment for his right shoulder. Accordingly, the Arbitrator finds that the work-related accident of April 29, 2015 caused

Petitioner's current condition of ill-being as it relates to his right shoulder based on the chain of events analysis.

In support of the Arbitrator's decision relating to "L," what is the nature and extent of the injury, the Arbitrator makes the following conclusions:

The Arbitrator concludes that as a result of the work-related accident of April 29, 2015, Petitioner sustained a serious injury to his right shoulder which resulted in permanent partial disability to the extent of 32.5% loss of use of the person as a whole. The Arbitrator's decision is supported by the credible and unrebutted testimony of Petitioner, the medical records submitted into evidence and the medical opinions of Respondent's Section 12 physician, Dr. Bush-Joseph.

The Arbitrator's finding is consistent with the factors and criteria set forth in Section 8.1(b) of the Act. Pursuant to Section 8.1(b) of the Act, the Arbitrator must consider certain factors and criteria in assessing permanent partial disability, including, the level of impairment under the AMA Guides, the occupation of the injured worker, the age of the injured worker, the future earning capacity of the injured worker and evidence of disability corroborated by the treating medical records. The Act provides that no single enumerated factor shall be the sole determinant of disability. After considering the factors, the Arbitrator finds that Petitioner is permanently partially disabled due to a serious injury to the right shoulder to the extent of 32.5% loss of use of the person as a whole. With respect to the factors, the Arbitrator finds the following:

A. Level of Impairment under the AMA Guides

Dr. Bush-Joseph prepared an AMA Impairment Rating Report. The report was admitted into evidence. Dr. Bush-Joseph found that Petitioner

sustained an impairment of 20% upper extremity impairment or 12% impairment to the whole person. Dr. Bush-Joseph testified that impairment is different than disability. He further testified that despite any analysis on the case, he was limited to a box in a grid when rendering an impairment rating. Dr. Bush-Joseph testified that there was a subjective component to the impairment analysis. Based on the testimony of Dr. Bush-Joseph that impairment is not disability, the analysis is subjective and that an impairment rating is limited, the Arbitrator accords this factor little weight.

B. Occupation of Petitioner

At the time of the work-related accident, Petitioner was employed by Respondent as a feeder driver. He lifted and carried fifty (50) to seventy (70) pounds. Petitioner grasped and reached as part of his job duties for Respondent. Petitioner operated a manual transmission vehicle. Petitioner used his right hand to constantly shift gears while driving. Petitioner also cranked handles. Petitioner performed pushing and pulling. Based on the testimony of Petitioner, the Arbitrator finds that Petitioner's occupation was physically demanding and required the constant and repetitive use of his right arm and shoulder. The Arbitrator accords great weight to the heavy physical demand of Petitioner's pre-injury employment.

C. Age of Petitioner

At the time of the accident, Petitioner was 56. At the time of the hearing, Petitioner was 59 years old. No evidence was presented as to how Petitioner's age affected his disability. However, the Arbitrator notes that Petitioner is an older individual who was working in a physically demanding occupation. Petitioner's age makes his disability greater. Accordingly, the Arbitrator finds that Petitioner's age increases his disability. *See Flexible Staffing Services v. Illinois Workers' Compensation Commission*, 2016 IL

App (1st) 151300WC (1st Dist. 2016) (holding that the Commission can make reasonable inferences from the medical evidence as it relates to how the claimant's age affects his disability). The Arbitrator accords great weight to the fact that Petitioner's age increases his disability.

D. Future Earning Capacity

No evidence was presented regarding Petitioner's current earning capacity. However, Petitioner testified that he experienced pain, stiffness and decreased range of motion at work. Further, he required assistance performing some of his job duties at work. Dr. Bush-Joseph, Respondent's Section 12 physician, testified that Petitioner should avoid lifting more than thirty (30) to 35 pounds. Dr. Chudik stated that if Petitioner's symptoms and pain persisted he would recommend permanent restrictions. Petitioner further testified that Dr. Chudik advised him to avoid performing activities which caused him pain. The Arbitrator finds it significant that as a result of the work-related accident of April 29, 2015, Petitioner requires assistance with his job duties and may require physical restrictions that could impact his future earning capacity. *See Flexible Staffing Services v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 151300WC (1st Dist. 2016) (holding that the Commission can make reasonable inferences from the medical evidence as it relates to how the claimant's work-related injuries affect his future earning capacity). Accordingly, the Arbitrator accords this factor great weight since Petitioner has difficulty performing his pre-injury job duties as a result of the work-related accident of April 29, 2015.

E. Evidence of Disability Corroborated by the Treating Medical Records

The medical records of Dr. Chudik and the opinions of Respondent's Section 12 physician, Dr. Bush-Joseph establish that Petitioner sustained an aggravation of glenohumeral arthritis resulting in the need for a total right shoulder replacement. The diagnosis was corroborated by the diagnostic studies, x-rays, operative report, medical records and objective evidence. The Arbitrator finds it significant that Respondent's Section 12 physician agreed with the diagnosis, necessity of the total shoulder replacement and serious nature of Petitioner's right shoulder injury.

Petitioner testified that he experiences subjective complaints, including pain, stiffness and decreased range of motion in the right shoulder. Dr. Chudik documented that Petitioner wanted to continue working; however, if the pain and soreness persisted than he would consider work restrictions in the future. Further, Petitioner relied more on his left arm at work than his right arm and asked for assistance. He performed his job duties differently than he did prior to April 29, 2015. He also stopped golfing, bowling and camping because of his work-related shoulder injury. The medical records of Dr. Chudik and the Section 12 report of Dr. Bush-Joseph corroborate Petitioner's subjective complaints.

The medical records clearly documented objective findings. The objective findings were documented in the medical records of Dr. Chudik and Dr. Bush-Joseph. Dr. Bush-Joseph documented that Petitioner experienced pain and weakness in his right shoulder with forward elevation and abduction. Dr. Bush-Joseph testified that Petitioner should avoid lifting more than thirty (30) to 35 pounds. Dr. Chudik also documented that Petitioner had pain, soreness and weakness in the right shoulder. Dr.

Chudik stated that if the pain and soreness persisted than he would consider permanent work restrictions. The objective findings are documented in the medical records, including the medical records of Dr. Chudik, FCE and diagnostic studies.

The Arbitrator further finds it significant that Dr. Bush-Joseph, Respondent's Section 12 physician, and Dr. Chudik recommended future medical treatment. Dr. Bush-Joseph testified that Petitioner would require annual follow up appointments and x-rays to monitor the shoulder replacement. He also stated that a home exercise program and over-the-counter medications were appropriate treatment. Dr. Bush-Joseph also discussed the possibility of a revision arthroplasty. Dr. Chudik recommended annual follow up appointments and x-rays.

The Arbitrator accords this factor great weight. The Arbitrator finds it significant that Petitioner's subjective complaints are consistent with the objective findings. Further, the Arbitrator finds it significant that Petitioner ongoing subjective complaints, weakness and may require future medical treatment.

Accordingly, based on the medical evidence and considering the above factors, the Arbitrator finds that Petitioner sustained the permanent partial disability to the extent of 32.5% loss of use of the person as a whole since he sustained a serious injury to the right shoulder as a result of the work-related accident of April 29, 2015.

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

Stanley Wilkos,
Petitioner,

18IWCC0557

vs.

NO: 15 WC 41104

American Airlines,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanency, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

18IWCC0557

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: SEP 10 2018
o8/30/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

WILKOS, STANLEY
Employee/Petitioner

Case# **15WC041104**

18IWCC0557

AMERICAN AIRLINES
Employer/Respondent

On 11/14/2017, 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 1.36% 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:

2208 CAPRON & AVGERINOS PC
MATTHEW B HEINIEN
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0075 POWER & CRONIN LTD
ANDREW LUTHER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

18IWCC0557

18IWCC0557

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)

Stanley Wilkos
Employee/Petitioner

v.

American Airlines
Employer/Respondent

Case # 15 WC 041104

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 **August 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. [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, **May 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$47,363.22**; the average weekly wage was **$910.83**.

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, 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

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care as prescribed by Dr. Evans and Dr. Hopkinson pursuant to 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.

#001 _____ November 13, 2017

Signature of Arbitrator — Date

ICArbDec19(b)

NOV 14 2017

I. Statement of Facts. 15 WC 111 317 Wilkos v. American

Petitioner is employed as a baggage handler for Respondent and as been for 31 years. The job requires him to load and unload planes and transport baggage. In his current role, Petitioner does local drives, whereby he loads and unloads planes and drives the baggage to and from the airplanes.

On May 1, 2015, while working at ORD while pulling chocks from underneath a parked airplane he slipped on glycol and fell to the ground. Petitioner testified that it was like he was doing the splits. Petitioner felt an immediate pain in the right femoral area and reported the incident to his employer. Petitioner continued to work thereafter and has continued to do so through the date of hearing.

On May 22, 2015, Petitioner saw his primary physician Dr. Andrew Pavlatos and reported that he stretched out his right femoral area when he slipped at work approximately 2 weeks ago. (PX 1, p. 4) Dr. Pavlatos' physical exam noted some swelling and pain, and diagnosed petitioner with a groin pull.

Petitioner testified that his pain fluctuated over the next several months and after it became unbearable, Petitioner sought further treatment. On October 27 he returned to Dr. Pavlatos with complaints of right hip pain radiating into his groin for 5 months. (PX 1, p. 8). Dr. Pavlatos prescribed a right hip X-Ray which was performed the following day, October 28, 2015, and which showed moderately severe degenerative changes in the right hip joint. (PX1 p.2

On November 9, 2015, Petitioner saw Dr. Douglas A. Evans professor and orthopedic surgeon with Loyola Medicine. Petitioner gave a history of a fall at work in May 2015 that led to increased pain over the anterolateral aspect of his hip radiating into the groin.

This patient reported he had no prior history but that he did have DVTs in 2010. After performing an exam and reviewing radiographs, Dr. Evans diagnosed Petitioner with right hip arthritis. Dr. Evans prescribed physical therapy and an intraarticular injection. (PX2, p. 4-5) On November 23, 2015, Petitioner received an intraarticular corticosteroid injection to his right hip. (PX2, p. 39)

On December 28, 2015, Petitioner returned to Dr. Evans and reported that he received significant improvement from the injection and that most of his pain is resolved. Dr. Evans noted that Petitioner had very limited range of motion and pain radiating down to his knee from his hip. (PX2, p. 12) Dr. Evans again prescribed physical therapy which Petitioner did not attend. On February 8, 2016, Petitioner returned to Dr. Evans for a follow up. Petitioner reported that the injection and his anti-inflammatory medicine, Voltaren, were still helping. Dr. Evans' exam revealed discomfort. he noted Petitioner continued to have improvement from the injection and that he will follow up as needed. (PX2, p. 19)

On September 21, 2016, Petitioner was examined at the request of Respondent pursuant to Section 12 of the Act by Dr. Charles Bush-Joseph. Petitioner reported that he continued complains of mild discomfort anteriorly and takes Celebrex as needed for the discomfort. Petitioner also reported that prior to the May, 2015 accident, he had not had hip pain, treatment or surgery. After taking a history, reviewing the diagnostic studies, and performing a physical examination, Dr. Bush-Joseph diagnosed end-stage severe right hip osteoarthritis.

On 9/21/16 Dr. Bush-Joseph felt that Petitioner's current state of ill being regarding his right hip was causally related to his accident at work, but that the accident caused a temporary exacerbation from which Petitioner has recovered. (emphasis added) Dr. Bush-Joseph felt that Petitioner reached maximum improvement approximately 4-6 weeks following the injury. (RX 1, p. 1-2)

On November 14, 2016 Petitioner returned to Dr. Evans and reported that he was having pain in his right hip and groin. Post exam Dr. Evans recommended a repeat injection and discussed whether to proceed with a total hip arthroplasty. Petitioner was not interested in proceeding with the procedure at that time. (PX 2, p. 25-26) On December 19, 2016, Petitioner received a right hip steroid/anesthetic injection. (PX 2, p. 41)

Petitioner testified that on May 22, 2017 he sought treatment from Dr. William Hopkinson with Loyola Medicine because he was the physician who would perform the total hip arthroplasty. Petitioner indicated that he was having increasing pain in his groin and lateral aspect of his hip. Further, he reported two fluoroscopic injections he had received only provided temporary relief. After taking a history, reviewing radiographs, and performing a physical examination, Dr. Hopkinson diagnosed Petitioner with work aggravated osteoarthritis, right hip, posttraumatic. Dr. Hopkinson recommended a right hip replacement surgery. (PX 2, p. 33-34) (Emphasis added to both Dr. Bush and Loyola findings.)

A careful reading of Dr. Bush-Joseph's opinion underscores his view the accident was a causative factor in the injury to the hip. Moreover, he states it was temporary exacerbation and akin to " he should have" recovered in a relatively short time. Contrawise, The treating records from Loyola Medicine document that to the contrary , the condition did not improve. (3.)

Thus, based upon the totality of the evidence, the Arbitrator finds in this particular case that the aggravation was such that it moved the hip's arthritic condition into the need for surgery as per the advise of two orthopedic surgeons at Loyola Medical Center.

In support thereof, the Arbitrator failed to find a prior prescription/ medical order for hip replacement prior to the accident. The workers complaints continued to the time both Dr. Evans plus Dr. Hopkinson ordered surgery. This erodes Dr. Bush-Joseph's speculation that the condition essentially should have improved. This case hinges on medical opinions, not advocacy by the attorneys- both of whom presented well organized cases in chief.

Conclusions of Law.

In support of the Arbitrator's decision on whether Petitioner's current condition of ill-being is causally connected to the accident ("F"), the Arbitrator concludes as follows:

The central issue in this case – from which all other issues derive – is whether Petitioner's current condition is due solely to his preexisting degenerative condition or whether it was aggravated or exacerbated by the accident of May 1, 2017.

Petitioner testified, and his medical records confirm, that he had never experienced any problems with his right hip or groin prior to his accident of May 1, 2015. The accident itself is not in dispute and Petitioner's medical treatment began shortly thereafter. Petitioner's treatment, although showing some interruption, has continued to the present. Any gaps in treatment were first, by reasonable evidence, the result of Petitioner's belief that he had a groin pull that would resolve, and later the temporary relief he received from two injections. Petitioner testified that at no point did his symptoms totally resolve.

Contrwise, Petitioner complained at each appointment of pain and/or discomfort in the anterolateral aspect of his hip radiating into the groin. Petitioner testified and records corroborate, that the symptoms that Petitioner suffers from today are the same as those he reported on May 22, 2015; symptoms that are consistent with the mechanism of injury. Furthermore, Petitioner testified that there have been no intervening accidents. All of the medical records and reports reference Petitioner's work accident as the triggering event for his ongoing symptoms.

Respondent's examining physician agrees that Petitioner's state of ill being is causally connected to the incident of May 1, 2015. (RX1, p. 2). However, Dr. Bush-Joseph opines in his report of September 21, 2016 that the incident caused only a temporary exacerbation from which Petitioner has now recovered. (RX1, p. 2) Dr. Bush-Joseph does not set forth a single piece of support for the opinion that Petitioner has recovered from the exacerbation. In his addendum of May 12, 2017, Dr. Bush-Joseph does add that the severity of the hip degeneration at the time of the injury brings into question Petitioner's denial of prior symptoms and that the sole basis for Dr. Evans' opinions are the Petitioner's subjective history. (RX2, p.1-2) In essence, it appears that Dr. Bush-Joseph does not believe Petitioner, speculating instead that Petitioner has recovered from the accident because he thinks he should have. The evidence does not support that contention.

It is well established that an accident need not be the sole or primary cause of a claimant's condition. Sisbro, Inc. v. Industrial Comm'n (Rodriguez), 797 N.E.2d 665 (2003). Instead, when an employee has a pre-existing condition, if the work-related accident aggravates or accelerates the pre-existing condition, then it is causally related to the work injury and not simply a result of normal degeneration. Id. (5.)

In a recent case, the Illinois Appellate Court took this a step further and discussed deterioration from a base line stating, "If a workers' compensation claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration." Schroeder v. Illinois Workers' Compensation Comm'n, 2017 IL App (4th) 160192WC. Similarly applicable is the proposition that where an accident accelerates the need for surgery, an employee may recover under the Act. Id.

In contrast to Dr. Bush-Joseph, Dr. Evans directly confronts this issues of aggravation and acceleration. In his progress note of November 14, 2016, Dr. Evans states, "Although the hip arthritis was clearly preexisting, he states that he was pain-free prior to the fall, and as a result, the fall clearly did exacerbate the preexisting arthritis. He does continue to be painful at this time, so I do not believe that the exacerbation is resolved." (PX2, p. 26) Dr. Evans' letter of January 9, 2017, further explains that while exacerbations can resolve, based on Petitioner's history and treatment, this work-related incident did aggravate symptoms and led to the required hip arthroplasty sooner than necessary. (PX3, p. 1-2) Dr. Hopkinson, in his sole progress note of May 15, 2017, explicitly diagnoses Petitioner with posttraumatic work aggravated osteoarthritis, right hip. (PX2 p. 34) It is unquestioned that Petitioner had osteoarthritis in his right hip. Any symptoms though, laid dormant and quiescent until this accident. The trauma of the accident caused the symptoms fire up and necessitated this course of treatment. That is the evidence in this matter.

Based upon the totality of the evidence, the Arbitrator adopts the medical opinions of Dr. Evans and Dr. Hopkins.. The Arbitrator finds the opinions of Dr. Evans and Dr. Hopkinson to be more persuasive than those of Dr. Bush-Joseph for several reasons, in this specific case at bar. First, Petitioner had worked for many years in a physically demanding trade without any prior history of hip problems. His symptoms began with the work accident of May 1, 2015. Second, although Petitioner's symptoms have waxed and waned with conservative treatment, they have generally remained consistent over the two years of treating records. Petitioner testified that at no time since his accident has he been symptom-free and the treating records generally corroborate this testimony. After any treatment gap, Petitioner reported to Drs. Pavlatos, Evans, Bush-Joseph, and Hopkinson that his symptoms began--and had persisted--since the accident at work. Lastly, there have been no other intervening accidents or traumas.

Based on the totality of the evidence, , the Arbitrator concludes that Petitioner's current condition of ill-being relative to his hip is causally connected to the accident of May 1, 2015.

In support of the Arbitrator's decision relating to whether Petitioner is entitled to prospective medical treatment ("K"), the Arbitrator concludes as follows:

There is no dispute that Petitioner needs a total hip replacement. Having determined that the Petitioner's current condition of ill-being is causally connected to the accident of May 1, 2015, the Arbitrator by a totality of the evidence- orders the Respondent shall authorize the surgical procedure recommended by Dr. Hopkinson, both in its pre-op and post op reasonable and related aspects of treatment.

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

Travis McReynolds,
Petitioner,

18IWCC0558

vs.

NO: 16 WC 20087

SOI/Shawnee Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and 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, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 2018, 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: SEP 10 2018
o8/30/18
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

18IWCC0558

McREYNOLDS, TRAVIS
Employee/Petitioner

Case# **16WC020087**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

On 2/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 21 2018

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

18IWCC0558

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

TRAVIS MCREYNOLDS
Employee/Petitioner

v.

STATE OF ILLINOIS/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

Case # **16** WC **20087**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **October 11, 2017**. By stipulation, the parties agree:

On the date of accident, **June 9, 2016**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$70,670.31**, and the average weekly wage was **$1,359.04**.

At the time of injury, Petitioner was **28** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

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

Respondent shall pay Petitioner compensation that has accrued from **September 7, 2017,** through **October 11, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

February 16, 2018
Date

FEB 21 2018

18IWCC0558

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

TRAVIS MCREYNOLDS
Employee/Petitioner

v. Case #: **16 WC 20087**

STATE OF ILLINOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on June 9, 2016, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 28 years old, single, and had no dependent children. He was employed by Respondent as a Correctional Officer and had been so employed for about six years. Petitioner testified that on June 9, 2016, he was attempting to break up an inmate fight when he fell to the ground and injured his lower back. He denied any prior injuries or treatment to his low back. He sought treatment with his primary care physician and then came under the care of Dr. Gornet, upon referral by his attorney. Treatment consisted of physical therapy and injections. He returned to work with no restrictions and has continued to work full duty since that time.

Following the accident, Petitioner presented to Rural Health on June 10, 2016, and was evaluated by Physician's Assistant Chelsea Treece. He gave a consistent history of the accident and reported pain in the middle and on the right side of his lower back. On examination, he had limited range of motion and tenderness in the L5 and right SI joint areas. PA Treece ordered an MRI and prescribed Cyclobenzaprine. PX3.

A lumbar MRI was performed on June 10, 2016, which showed (1) L4-5 moderate spinal canal narrowing due to a combination of a central posterior disc protrusion and degenerative change, with abutment and probable compression of the bilateral descending L5 nerves; (2) neural foraminal narrowing, moderate at L4-5 and mild to moderate at L3-4 and L5-S1 bilaterally; and (3) chronic Schmorl's nodes at L1 and L2. PX4.

On June 28, 2016, Petitioner presented to Dr. Matthew Gornet at The Orthopedic Center of St. Louis. It was noted that he was referred by PA Treece and that Petitioner's parents were also patients of Dr. Gornet. He reported a consistent history of the accident and complained of low back pain to the right side, particularly the right buttock, hip, and upper thigh. On examination, there was pain in his low back, right buttock and right hip. Straight leg raise was positive for pain on the right. Dr. Gornet reviewed the MRI, criticized its quality, and ordered a repeat study. The updated MRI was obtained the same day which revealed (1) central annular tear at the apex of a central broad-based protrusion at L4-5 resulting in moderate central canal stenosis and bilateral foraminal stenosis; and (2) small old Schmorl's node protrusions at L1 and L2. Dr. Gornet interpreted the MRI to show "a large central herniation at L4-5 with a large annular tear". He recommended physical therapy, anti-inflammatories, and muscle relaxants. He noted if Petitioner did not improve then injections would be considered. Petitioner was kept off work. PX5, PX6.

On July 7, 2016, Petitioner presented to Southern Illinois Healthcare for an initial physical therapy evaluation. He underwent therapy on a consistent basis throughout the months of July and August. The discharge summary of August 25, 2016, notes he regained the range of motion in his back but he continued to have good and bad days. He reported that it did not take a lot to aggravate his back symptoms. PX10.

Petitioner returned to Dr. Gornet on September 15, 2016, and reported he continued to have significant pain in his low back, right buttock, right hip, and right thigh. It is unclear whether an examination took place on this date, as the note does not reference same. Dr. Gornet referred Petitioner to Dr. Blake for a steroid injection at L4-5 on the right. He noted, "If he is not improved, consideration could be given to fusion or disc replacement surgery at L4-5." PX5.

On October 4, 2016, Petitioner underwent a left L4-5 epidural steroid injection with fluoroscopy by Dr. Helen Blake. The Arbitrator notes that Dr. Gornet's record indicates the injection was to be at L4-5 on the right, rather than the left. PX7.

Petitioner returned to Dr. Gornet on December 1, 2016, and reported he had a limited response from the injection and felt his symptoms had returned. Dr. Gornet noted, "I think his best option in this circumstance would be a disc replacement at L4-5." He noted that a microdiscectomy with such a large annular defect would not be wise, and that a microdecompression would not rectify the large structural problem. However, he noted that Petitioner had improved from the injection and believed his best option at that time would be a "trial" return to work full duty. He believed Petitioner needed additional treatment and had not reached maximum medical improvement. It is unclear whether a physical examination took place on this date, as the record makes no mention of same. PX5.

On February 6, 2017, Petitioner followed up with Dr. Gornet, who noted that not only had Petitioner gone through his "trial" of return to work full duty, but he had actually been promoted. Dr. Gornet further noted that Petitioner "still has significant symptoms"; however, he did not describe or detail what any of those symptoms were. With regard to an examination, Dr. Gornet commented only that "exam shows no focal neurologic deficit". He dispensed medications of Ibuprofen and Cyclobenzaprine, and referred Petitioner for another injection at L4-5 on the right. He allowed Petitioner to continue working full duty but indicated he was not at MMI. PX5.

On March 2, 2017, Petitioner underwent a right L4-5 epidural steroid injection by Dr. Kaylea Boutwell. Diagnosis was right lumbar radiculopathy. PX8.

Petitioner returned to Dr. Gornet on May 10, 2017, and reported he was working full duty but still having symptoms. The symptoms were not described or detailed. Petitioner reported that the second injection had helped, and Dr. Gornet commented that "only time will tell whether this is short or long term relief". PX5.

On September 7, 2017, Petitioner followed up with Dr. Gornet. It was noted, "He states that overall he is doing very well. He is working full duty. He has minimal symptoms." Dr. Gornet provided refills of Ibuprofen and Cyclobenzaprine and noted that further refills could be provided by Petitioner's primary physician. He noted that Petitioner's exam was "non-focal" but provided no further details. He noted that Petitioner was "clinically doing very well" and placed him at maximum medical improvement, to follow up only on an as needed basis. PX5.

Petitioner testified that he continues to have stiffness and soreness when he wakes up, has difficulty sleeping, notices tightness in his back with prolonged sitting or standing, and has to periodically change positions. He also experiences pain while engaging in tactical practice at work. Petitioner testified that his hobby of dirt bike racing has been affected, as the riding is painful and it "takes days to recover" and it is "not worth it". His hobby of weight lifting has similarly been affected. Petitioner testified he takes Flexeril and Ibuprofen on a daily basis. On cross-examination, Petitioner acknowledged that he had returned to work full duty, is not under the care of any physician, and does not wear any sort of device or brace.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although Petitioner's date of accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to Subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Correctional Officer at the time of the accident and that he was able to return to work in that capacity without any restrictions or limitations as a result of said injuries. He continues to be a part of the tactical team as well. He testified he performs all of his duties, though sometimes does so with pain. Although Petitioner did not detail his job duties, the

Arbitrator recognizes that the position can be physically demanding at times. The Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 28 years old at the time of the injury. He is obviously very young, and has many work years ahead of him, during which he must deal with his disability. Over time his condition could improve, stay the same, or get worse. However, he appears to have made a good recovery. The Arbitrator places some weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, there was no evidence that Petitioner's future earning capacity has been or will be impacted as a result of this injury. As such, the Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner sustained disc herniation with an annular tear at L4-5. He underwent conservative care consisting of two months of physical therapy and ultimately two epidural steroid injections. Dr. Gornet opined that Petitoner's resulting symptoms were causally related to his accident. Respondent did not have Petitioner examined. Petitioner testified that he improved with the injections and was able to return to full duty work. However, he continued to have pain, stiffness, soreness, difficulty sleeping, tightness in his back with prolonged sitting or standing, and pain while engaging in tactical practice at work. His hobbies of dirt bike racing and weight lifting have also been affected. He testified he takes Flexeril and Ibuprofen on a daily basis for his symptoms. Dr. Gornet noted in his final treatment record of September 7, 2017, that, "He states that overall he is doing very well. He is working full duty. He has minimal symptoms." He further noted that clinically Petitioner was also doing very well. The Arbitrator notes there is a bit of difference between Petitioner's testimony and what is recorded in the treating medical records, which goes to the assessment of his disability. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 7.5% loss of use of the body as a whole (37.5 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,359.04. The Arbitrator finds his permanent partial disability rate is $755.22, the maximum rate in effect for his date of accident.

1`1`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

Julio Hernandez,
Petitioner,

vs.

Castwell Products LLC,
Respondent.

18IWCC0559

NO: 11 WC 40941

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, extent, permanency, 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 August 22, 2017, is hereby affirmed and adopted.

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

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

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.

SEP 10 2018

DATED:
o8/30/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED 8(a)

18IWCC0559

HERNANDEZ, JULIO
Employee/Petitioner

Case# **11WC040941**

CASTWELL PRODUCTS LLC
Employer/Respondent

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
DEREK S LAX
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

1454 THOMAS & PORTELA
ROBERT L BELMONTE
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0559

18IWCC0559

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
8(A) & NATURE AND EXTENT

Julio Hernandez
Employee/Petitioner

v.

Castwell Products, LLC
Employer Respondent

Case # 11 WC 40941

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Michael Glaub, Arbitrator of the Commission, in the city of **Chicago**, on **May 30, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

F. [x] Is Petitioner's current condition of ill-being causally related to the injury as it relates to his Lumbar Spine?

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. [x] Other - NATURE AND EXTENT

18IWCC0559

FINDINGS

On the date of accident, **9/21/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is* causally related to the accident as it relates to both Feet.
Petitioner's current condition of ill-being is not causally related to the accident as it relates to his low back.

In the year preceding the injury, Petitioner earned **$34,456.76**; the average weekly wage was $662.63.

On the date of accident, Petitioner was **35** 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 **$33,383.67** for TTD, **$0** for TPD, **$0** for maintenance, and N/A for other benefits, for a total credit of **$33,383.67**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $441.75/week for 92 2/7ths weeks, commencing 9/22/11 through 3/18/12 and 3/25/13 through 7/3/14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,076.00 to Orthopaedic and Rehab Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all other medical benefits that have been paid pursuant to the Fee Schedule listed and attached to Arbitrator's Exhibit 1. Pursuant to the Fee Schedule, the outstanding bills that are owed total $2,076.00. From Petitioner's exhibit of medical bills entered into evidence the majority of outstanding charges appear to be balance billing.

Respondent shall not authorize and pay for the Lumbar Spine MRI prescribed Dr. Jennifer Conner.

Respondent shall pay Petitioner the sum of $397.58/week for a further period of 200 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a loss of 40% MAW.

RESPONDENT SHALL PAY ANY COMPENSATION ACCRUED FROM JULY 3, 2014 THROUGH MAY 30, 2017, AND SHALL PAY THE REMAINDER OF THE AWARD, IF ANY, IN WEEKLY PAYMENTS.

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

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

Signature of Arbitrator

August 18, 2017
Date

AUG 22 2017

Julio Hernandez v Castwell Products, LLC
11 WC 40941
Addendum – Statement of Facts and Conclusions of Law
Respondent

STATEMENT OF FACTS

The parties tried this case under Section 8(a) of the Act for prospective medical care. However, the parties requested the Arbitrator to tender a Decision on all issues in the event the request for prospective medical care was denied. The parties did offer testimony and evidence on all issues.

The Petitioner testified that he worked for the Respondent for more than 9 years as a forklift driver and a machine operator. On September 21, 2011 the Petitioner testified that he was returning from a bathroom break when he was struck by another forklift being driven by a co-worker. Accident and Notice is not in dispute. Due to the limited area to move in the hallway in which the Petitioner was walking, the Petitioner testified that he threw himself backwards landing on his back causing the forklift to first run over his right leg, and then the entire weight of the forklift onto his left leg. The Petitioner further testified that he was dragged almost 2 meters. The Petitioner testified that coworker needed to reverse the forklift to completely free his legs.

The Petitioner testified that he was taken via ambulance to St. Francis Hospital. (PX 6) Due to the significant nature of Petitioner's injuries he was admitted into the hospital where he stayed from September 21, 2011 to October 7, 2011. The Petitioner testified that while admitted to the hospital he underwent 6 surgeries to correct his injuries.

1. *Debridement of open fracture metatarsal of Right and Left Foot – 9/22/11*
2. *Debridement of both the Right and Left Foot – 9/24/11*

3. *Open Reduction Internal Fixation of both the Right and Left Foot– 9/27/11*
4. *Debridement open fracture of Metatarsalof Left Foot – 9/30/11*
5. *Debridement of open fracture Metatarsalof Left Foot – 10/3/11*
6. *Debridement of Fracture Metatarsal of Left Foot– 10/5/11*

Following the Petitioner's discharge from the hospital, the Petitioner testified that he went to live with his mother so that he could be properly cared for as well be assisted by a home health care nurse who changed his dressings, and assisted with daily tasks such as washing, shaving, and changing his clothes. Due to the excessive nature of his injuries the Petitioner testified that he had to lie down in bed for 5 months, and had to learn how to walk again with the assistance of a home physical therapist as well.

The Petitioner began to follow up with his treating physicians, Dr. Roberto Levi, and Dr. Jennifer Connor at Orthopedic and Rehabilitation Centers on October 13, 2011. The Petitioner testified he was taken by special ambulance to their clinic due to his inability to walk and that he lived on the 6th Floor which made it extremely difficult to get up and down stairs. The Petitioner testified that he did not formally begin a course of formal Physical Therapy until January 3. 2012. The Petitioner testified that he was taken off of work by his treating doctors and began to receive Temporary Total Disability Benefits. The Petitioner noted he did not initially receive the correct amount of TTD, but that it was eventually adjusted to the correct rate of pay. The records and the Petitioner's testimony show that the Petitioner regularly attended his doctors and therapy appointments.

The Petitioner testified that on March 12, 2012 his treating doctors provided him with light duty restrictions and that he returned to work on March 19, 2012. The Petitioner testified that the Respondent accommodated him to the best of his abilities and allowed him to attend monthly

doctors appointments and physical therapy. The Petitioner testified he began a second course of physical therapy at the request of his doctors on August 27, 2012 and continued until October 3, 2012.

On March 25, 2013 the Petitioner testified that he was experiencing more pain, and his treating physicians took him back off of work, and ordered new MRI's of both of his feet as well as an FCE. The Petitioner additionally testified that he was having pain in not only his feet, but his lower back as well. (TX pg. 25) The Petitioner testified he began to receive his TTD benefits as the Respondent honored his off work status. The Petitioner's new MRI's of the Left and Right Feet were taken on April 10, 2013 at Lutheran General Hospital which showed a stress fracture in the Fifth Metatarsal of the Left Foot and Right Foot along with significant degenerative changes, and moderate osteoarthritis of the 4th metatarsal. Upon review of these images on April 22, 2013, his surgeon, Dr. Levy found that an FCE was unnecessary, and that these new stress fractures were probably the result of the Petitioner walking on his feet from his injuries. The Petitioner remained in a off work fashion, was told to continue physical therapy, and was given medication.

The Petitioner underwent an Independent Medical Evaluation on August 21, 2013 with Dr. Steven Mash at M & M Orthopedics. The report documents the Petitioner's road of recovery and notes that the Petitioner should be considered at MMI with Permanent Restrictions if the Petitioner does not want further surgery to keep up with improvement. Dr. Mash also indicates that the Petitioner cannot return to work as a forklift driver, he should not work outside in a cold environment, but sedentary work inside with not being asked to stand or walk though out the day. Climbing would also be difficult.

Following another month of Physical Therapy at ATI from August 27, 2013 through September 27, 2013, the Petitioner returned to his treating physicians. The Petitioner testified that

he returned to Orthopedic and Rehab Centers where he formally complained of pain in his back and both of his feet. The Petitioner was continued off of work, to continue his medications, told to continue following up every month, and was prescribed an MRI of his Lumbar Spine. The Petitioner testified that he always had pain in his back, but could not account for why this visit on September 26, 2013 was the first time that his Lumbar Spine was mentioned in his records. The Petitioner from this point on continuously complained of back pain although no treatment was performed to the back other than an X-Ray, followed up monthly for work status updates and refills of his medications. The Petitioner received a letter to return to work in an accommodated fashion on October 16, 2013. The Parties have stipulated and Respondent's RX 8, along with the Petitioner's testimony that he he continued to receive TTD benefits through February 27, 2014 due to his ongoing back pain, the need to work out what his specific job duties would entail, and for the Respondent to obtain a Section 12 examination for his lumbar spine.

The Petitioner underwent an Independent Medical Evaluation with Dr. Michael Kornblatt on February 27, 2014. Dr. Kornblatt found that the Petitioner's complaints of pain in his spine were unrelated to the original date of accident of September 21, 2011 and was not causally related to the Petitioner's bilateral foot injuries. Dr. Kornblatt did conclude that the Petitioner should only participate in aerobic exercise and an MRI would be medically unnecessary.

The Petitioner testified that his treating physicians kept him off work through July 3, 2014. During this time between the Independent Medical Examination of February 27, 2014 and July 3, 2014 the Petitioner testified that he did not receive TTD benefits. Following his July 3, 2014 appointment, the Petitioner testified that he returned to work for the Respondent as an Inspector. The Petitioner testified that the Respondent is accommodating him with a sedentary position that calls for the inspection of tiny parts that are about 2 inches long that are produced by the

Respondent. (TX pg. 52) The Petitioner testified that his job duties are a lot different than they once were. He is no longer a machine operator, or a forklift driver. The Petitioner further stated that the Respondent allows him to keep a heater on his feet. The Petitioner's testimony and the records show that he continuously follows up with his treating physicians monthly at the present time. The Petitioner is prescribed medication of Fexmid, Norco, Terocin Patches, and Gabapentin. The Petitioner continuously has been prescribed custom insoles, a lumbar MRI, and referral for a psychological evaluation. These have not been approved or authorized. The Petitioner has recommendations for surgery for his foot fractures now and possibly in the future, but is hesitant to undergo any more surgery as there is no guarantee that he will be made better, and could more likely make him worse off than he is now.

The Petitioner testified that this accident has had a traumatic effect on his life. The Petitioner acknowledged that he cannot walk long distances, drive long distances, he cannot be in the cold, and he can no longer go dancing. Further, the Petitioner stated that he cannot do heavy labor, and he is afraid of losing his position once this claim is over. The Petitioner testified that he has to wear gym shoes for comfort of his feet. On the date of trial the Petitioner was wearing Velcro gym shoes. To date the Petitioner has testified that he is being fully accommodated with work, and that they allow him to take breaks, stand up, and to attend all of his doctor's appointments.

The Petitioner testified that he felt with all of the pain and suffering, his injuries, his lost time that his claim was worth $500,000.00 at a minimum. (The Arbitrator advised the Petitioner that his award would be based on statutory language set forth in the Workers' Compensation Act, and precedent from prior decisions.)

Cross Examination of Mr. Hernandez

The Petitioner testified that his medical records from St. Francis did not indicate head, or back trauma because the Emergency Room doctors were focused on both of his feet. The Petitioner testified that he had back pain throughout his claim, and his therapists told him it was due to laying down in the bed for so long, and the weight that he gained from not exercising. The Petitioner again acknowledged that his job duties are far less than what they once were. The Petitioner testified that he typically works 40 hours a week, and sometimes more if needed for example on Saturdays. The Petitioner testified that he does not take medication while working and that he takes it every night to help him sleep, for foot cramps, and to ease the pain.

The Respondent offered no testimony of any witnesses at trial.

Deposition of Dr. Jennifer Connor

The deposition of Dr. Jennifer Connor was taken on October 6, 2016. Dr. O'Connor testified as to the Petitioner's entire history of treatment, the pain medication he still takes due to his bilateral foot injuries, and the possible need for additional procedures. (PX 1) Dr. O'Connor testified that both herself and her partner, Dr. Roberto Levi participated in the treatment of the Petitioner. Dr. Connor noted that it was not uncommon for the Petitioner to slowly recover from this type of accident, and that she could understand his frustrations. (PX 1 at pg. 16). Dr. Connor testified that his first noted complaints of back pain were in the visit of September 26, 2013. (PX 1 pgs 20-24) Dr. Connor felt that he had a possible degenerative or pre-existing condition of Spondylothesis that may not have been caused from lying down, or walking, but that this injury could most certainly exacerbate his condition. (PX 1 at 24) Dr. Connor discussed a possible future procedure of a Resection Arthroplasty where you remove part of the bone and replace it with some sort of option, but that would need to be determined. (PX 1 at 25-26) Dr. Connor noted that the Petitioner's bilateral feet problem would be chronic, and that he would need to be continuously

treated with pain medication, possible therapy, possible future surgery, and possibly custom insoles. (PX 1 at 27) Dr Connor testified that she prescribed a lumbar MRI, and a referral for a physiatrist, but was unaware that he ever went, and that she could not force the Petitioner to put the Lumbar MRI under his group insurance. Dr. Connor testified that there was no mention of back complaints until September 26, 2013, but she felt that Dr. Kornblatt who performed the IME was not fully informed without the diagnostics. (PX 1 at 40)

CONCLUSIONS OF LAW

F. WITH REGARD TO ITEM (F), IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY AS IT RELATES TO THE LUMBAR SPINE, THE ARBITRATOR RENDERS THE FOLLOWING FINDING OF FACT AND CONCLUSIONS OF LAW:

All parties agree that the Petitioner's right and left foot conditions are causally related to his work injuries September 21, 2011. The respondent does dispute that the petitioner's low back condition is causally related to the accident of September 21, 2011.

The Petitioner was injured in an alleged work related accident on September 21, 2011 when he was run over by a forklift driven by a co-worker. Petitioner's initial medical records from St. Francis Hospital do not document that the Petitioner complained of acute back pain, and moreover does not indicate back pain for over 2 years in his medical records. The Arbitrator does not find the Petitioner's testimony to be persuasive as it relates to his alleged lumbar condition. The Petitioner testified that he never has sustained prior injuries to his back but he was working full duty prior to his alleged work related accident of September 21, 2011 with no complaints of back pain. It has been noted by his foot specialists that conservative care has failed, and that the Petitioner would benefit from a lumbar MRI to determine the true problems with his back. The

Arbitrator does not find this to be persuasive. The Arbitrator finds that the Petitioner's low back condition is not causally related to the September 21, 2011 work related injury. The Arbitrator finds that the Petitioner's left and right foot conditions of ill-being are causally related to the September 21, 2011 work-related injury.

J. WITH REGARD TO ITEM (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator finds that the medical services provided to the Petitioner were reasonable and necessary and that the Respondent has not paid all appropriate charges. The Petitioner sustained an injury to his Right and Left Foot as a result of his September 21, 2011 work related injury. The Petitioner underwent multiple surgeries, physical therapy, diagnostic testing, casting, Cam Walker Boots, was prescribed pain medication and doctor's visits to treat his condition. This so far has been conservative course of treatment. Accordingly, the Arbitrator finds that the Petitioner's treatment has been reasonable and necessary.

The Arbitrator finds that the Respondent has not paid all appropriate charges. Further, the Petitioner produced outstanding medical bills. (PX 2) Having found the Petitioner's treatment to be reasonable and necessary, the Arbitrator hereby awards the Petitioner's outstanding medical bills as reflected in Petitioner's Exhibit #2. The Respondent shall be given a credit for any and all paid charges pursuant to the fee schedule. The Arbitrator takes notice that there appears to be balance billing as it relates to some of the charges and the Respondent shall not be responsible for any balance billing. The Arbitrator concludes that the amount of unpaid medical to be $2,076.00 due to the improper balance billing.

K. WITH REGARD TO ITEM (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator finds that the Petitioner is not entitled to prospective medical care in the form of a lumbar MRI recommended by Dr. Jennifer Conner. The Arbitrator found there was no causal connection between his alleged September 21, 2011 injury and his lumbar spine complaints.

L. WITH REGARD TO ITEM (L), WHAT TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator finds that the Petitioner is entitled to TTD benefits from September 22, 2011 to March 18, 2012 and March 25, 2013 to July 3, 2014. The Petitioner's medical records establish that the Petitioner has been medically unable to work or has been provided light duty work restrictions that have not been accommodated by the Respondent since his accident of September 21, 2011. (*See Generally* Pet. Ex #1 through #8) The Petitioner testified that he was mostly paid his TTD benefits but is missing 16 weeks of TTD that was cut off on February 27, 2014. The Petitioner has been in an off and on work status since his September 21, 2011 accident. Accordingly, the Petitioner is awarded TTD benefits from September 22, 2011 to March 18, 2012 and March 25, 2013 to July 3, 2014 payable at a rate of $444.75 per week.

O. WITH REGARD TO WHAT IS THE NATURE AND EXTENT OF THE PETITIONER'S INJURIES, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator finds that the Petitioner was injured to the nature and extent of 40% MAW. As a result of the Petitioner's injuries he has suffered permanent partial disability as a result. The Petitioner underwent diagnostic testing and multiple surgeries. He has received extensive post-operative care and continues to treat with his treating surgeon. Petitioner also takes pain medication for his chronic problems with both of his feet. There were positive findings on the Petitioner's MRI scan to his Right Foot and Left Foot. The Petitioner and his treating doctor testified that petitioner still takes prescription medication, that he needs insoles for his feet, and may need future surgeries to correct his problems. The Petitioner has difficulty with his feet when the weather gets cold, and during continuous walking and driving with his feet. Further, the Petitioner testified that he has some difficulty performing all of his required job functions on occasion.

The Arbitrator has taken into consideration all 5 factors under Section 8.1b(b).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that there was NOT a permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Laborer at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes Petitioner has not successfully returned to full duty employment, but that this type of occupation is considered a very heavy physical demand level and this type of employment can cause strain on the Petitioner's Right and Left Foot. Because of Petitioner's capacity to perform his job with difficulty doing certain functions of his job, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 35 years old at the time of the accident. Because of the Petitioner's age and his ability to heal slower from doing certain activities, the Arbitrator therefore gives greater weight to this factor as he will have to deal with this condition for a relatively long work-life.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner did return to work in a capacity that would hinder his earning capacity. Because of his return to work and not retaining future earning capacity, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes, that the Petitioner was released per her treating physician back to a light sedentary position after undergoing multiple surgeries and extensive treatment that he still undergoes today. 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 40% MAW pursuant to §8(d) 2 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 COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NORMA BAKER as widow of
RONALD BAKER,

Petitioner,

vs. NO: 13 WC 20051

CHICAGO PARK DISTRICT,

Respondent.

ORDER

This matter coming before Commissioner Michael J. Brennan pursuant to Respondent's Motion to Dismiss its Review filed September 4, 2018. Pursuant to the motion, the Respondent alleges that the Arbitrator's award has been paid and, therefore, requests that the Commission dismiss its Petitions for Review filed March 14, 2018, April 24, 2018, and April 27, 2018.

A telephone conference was held between Commissioner Brennan and the parties on September 7, 2018. Respondent's attorney advised that Respondent wishes to dismiss its Review of the Arbitrator's decision as previously filed. Petitioner's attorney advised that Petitioner is still pursuing her Petition for Review filed April 19, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss its Review is hereby granted, and Respondent's Petitions for Review filed May 1, 2018; April 27, 2018; April 24, 2018; and, March 14, 2018 are hereby dismissed.

IT IS FURTHER ORDERED BY THE COMMISSION that this case will be set for oral argument pursuant to Petitioner's Petition for Review only.

DATED: SEP 17 2018
MJB/tdm
9/7/18
052

Michael J. Brennan
Commissioner

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

Victoria M. Collazo,

Petitioner,

vs. NO: 14WC 19991

Eklind Tool Company,

Respondent.

18IWCC0560

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, causal connection, medical expenses, prospective medical care, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 22, 2018 is hereby affirmed and adopted.

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

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: SEP 18 2018
SJM/sj
o-8/30/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

COLLAZO, VICTORIA
Employee/Petitioner

Case# **14WC019991**

EKLIND TOOL COMPANY
Employer/Respondent

18IWCC0560

On 1/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS MENCHETTI ET AL
MICHAEL A ROM
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
STEVEN W JACOBSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION
19(b)

18IWCC0560

Case # 14 WC 19991

VICTORIA COLLAZO,
Employee/Petitioner

v.

Consolidated cases:

EKLIND TOOL 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 **KETKI STEFFEN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **September 22, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other

FINDINGS

18IWCC0560

On the date of accident, May 30, 2014, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did ***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 $31,872.00; the average weekly wage was $612.92.

On the date of accident, Petitioner was 35 years of age, ***married,*** with 3 dependent children.

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

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

Respondent is entitled to a credit of **$51,143.08** under Section 8(j) of the Act.

ORDER

Denial of benefits

No benefits are awarded on the basis that the Petitioner failed to prove an accidental injury arising out of and in the course of employment due to the absence of a causal connection between the employment and Petitioner's conditions of ill-being.

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.

KSSteffen

Signature of Arbitrator Ketki Shroff Steffen

January 10, 2018

Date

ICArbDec19(b)

JAN 22 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

18IWCC0560

Victoria Collazo,)
)
Petitioner,)
) No. 14 WC 019991
vs.)
)
Eklind Tool Company,)
)
Respondent.)

FACTUAL HISTORY

Testimony of Petitioner

The Petitioner began working for the Respondent as a customer service representative in July, 2008. The customer service position essentially involved receiving purchase orders from customers and entering those orders into the Respondent's computer system. The Petitioner testified her employment activities included accepting phone calls, receiving purchase orders via phone and email, and entering data. The Petitioner further testified she handled international accounts which typically involved larger orders and also required additional paperwork on the computer. The Petitioner testified she worked on a full-time basis and devoted 90% of her time engaged in computer work. (T. 16)

The Petitioner also testified to certain deficiencies regarding her workstation. According to the Petitioner, her chair was incapable of being adjusted for height and she was seated lower than she should have been. (T. 18-19) The Petitioner worked with two computer monitors resting on bulk copy paper which elevated the monitors a few inches. (T. 19) The Petitioner testified that her hands were positioned at a 30 to 40-degree angle while typing. (T. 21-22) The Petitioner further testified, however, that her work station was equipped with a soft handrest for her wrists which she used while typing. (T. 23)

The Petitioner testified she began noticing symptoms in her hands in April, 2014. (T. 29-30) The medical records reflect that the Petitioner sought treatment with her primary care physician, Dr. Cabrera, on April 28, 2014. (Px1 and Rx15) The Petitioner complained of bilateral hand pain and numbness. Dr. Cabrera noted positive findings on Phalen's and Tinel's testing. Dr. Cabrera diagnosed carpal tunnel syndrome (CTS) and prescribed wrist splints. He also recommended Petitioner see an orthopedic physician for consultation. Dr. Cabrera's records noted the Petitioner's height and weight as 5'7" and 220 lbs. (Rx15)

On May 30, 2014, the Petitioner presented to Dr. Roberto Levi with bilateral hand numbness in the region of the median nerve. (Px 2) The Petitioner reported she had suffered these symptoms for "a few years" and had been working with computers for the past six years. The Petitioner provided a family history for Lupus and a personal history for hysterectomy. On examination, Dr. Levi noted positive Phalen's testing bilaterally and a positive Finkelstein's test in the left wrist. Dr. Levi diagnosed bilateral CTS and left-sided DeQuervain's tenosynovitis. Dr. Levi specifically commented that "on the right, she has only carpal tunnel syndrome." Dr. Levi also indicated it was his impression that the Petitioner's

condition was due to her employment. He ordered an EMG test and advised the Petitioner to return in two weeks with workers' compensation information.

The Petitioner testified she reported her injury to the Respondent, after which the Petitioner was asked to complete a questionnaire at the request of the Respondent's claims administrator, CCMSI. (T. 36, Px#10) The questionnaire was captioned Ergonomic/Cumulative Trauma Questionnaire and was completed June 3, 2014. On this form, the Petitioner indicated that she reported the accidental injury on June 2, 2014. On June 5, 2014, Respondent's vice president, Doug Cunningham, sent an email to eight employees including the Petitioner announcing that a "Meredith Wayant from CCMSI" would be visiting the company to perform an ergonomic analysis "in light of our upcoming relocation and provide recommendations for improvements." (Px#11) The email announcement also indicated that the company would also be discussing chairs. The recipients who received this email announcement included employees who did not perform the same job as the Petitioner. (T. 37) The Petitioner testified that the entire customer service department was being relocated; however, she believed the ergonomics consultation was arranged due to her reported claim. (T. 27, 38, 39)

During the visit by the ergonomics consultant, the Petitioner was advised to retract the keyboard feet to place her board in flat-level mode. (T. 20) The Petitioner testified she had previously worked with her keyboard raised during her entire employment until the ergonomics consultant recommended flat-level mode. (T.20) According to the Petitioner, she was unaware that her keyboard should be flat. (T.22) With the feet extended, the keyboard was raised by one inch. (T. 23) The Petitioner testified further that the Respondent was planning to purchase new chairs for the work stations; however, she left her employment before the new chairs arrived (T.26). The Petitioner was shown a photo of her workstation (Respondent's Exhibit # 1), and she agreed that that the exhibit accurately depicted her workstation. (T. 27-28) She identified the chair and the handrest pad.

The Petitioner testified that Dr. Levi issued work restrictions for wearing wrist braces and she continued working. (T. 39) The Petitioner further testified that Dr. Levi indicated she should not be performing repetitive motion. (T.39) At the Respondent's request, the Petitioner signed a document entitled "Employee Acknowledgement of Modified Work." (Px#13) By signing this document, the Petitioner agreed to work within her restrictions. (Px# 13) According to the Petitioner, however, the Respondent failed to honor Dr. Levi's restrictions. (T.41) The Petitioner testified she continued to perform her computer data entry duties, stating that: "Nothing had changed, other than the fact that I wore a brace." (T.41) The Arbitrator notes, however, that Dr. Levi's May 30, 2014 work status report indicated only that the Petitioner "must wear braces" and did not preclude the Petitioner from working on a computer. (Rx#21) The Petitioner testified she continued to work in her same job with a wrist brace until June 20, 2014. (T. 43)

On June 20, 2014, Dr. Levi re-evaluated the Petitioner and noted that an EMG test performed at St. Joseph Hospital was normal. (Px#2) Dr. Levi recommended that a repeat test be performed in 30 days. His diagnosis remained unchanged and he placed her on off work status at that time. (T.41) On July 1, 2014, the Petitioner commenced physical therapy at Dr. Levi's clinic. (Px#2) On July 25, 2014, a repeat EMG test demonstrated evidence for bilateral cervical radiculopathy affecting the nerve root levels at C6 and C7. The test was negative for carpal tunnel syndrome.

On July 31, 2014, Dr. Sam Biafora performed a Section 12 examination at Respondent's request. (Rx#11) Per his report dated August 4, 2014, Dr. Biafora diagnosed bilateral hand numbness suspicious for carpal tunnel syndrome and he recommended a repeat EMG. Dr. Biafora found a positive Finkelstein's on the left wrist and diagnosed left-sided DeQuervain's. By way of history, Dr. Biafora noted that the Petitioner is right-hand dominant and used her *right* hand for mouse clicking. Dr. Biafora

opined that the Petitioner could perform computer work with wrist braces. He further opined that the Petitioner's CTS was not related to her occupation on the basis that computer entry work does not involve the application of force over prolonged periods of time. He also opined that the Petitioner's left-sided DeQuervain's was not work-related on the basis her computer work did not involve forceful gripping or pinching.

On August 13, 2014, a claims adjuster from CCMSI mailed a letter to the Petitioner notifying her that her claim was denied based on Dr. Biafora's opinions. The letter urged the Petitioner to use her group health insurance plan for treatment. (Rx#18) On August 22, 2014, the Respondent sent a letter to the Petitioner offering her light duty work based on Dr. Biafora's report. (Rx#6) The Petitioner did not respond.

When the Petitioner returned to Dr. Levi for follow-up on August 13, 2014, Dr. Levi discussed the EMG test results showing radiculopathy, in response to which the Petitioner stated "that occasionally she has neck pain." (Px#2) Dr. Levi ordered a cervical spine MRI to further assess. Dr. Levi also noted continuing wrist symptoms and he injected the left wrist to help improve the left de Quervain's.

The Petitioner continued receiving physical therapy. Of note, on September 2, 2014, the Petitioner reported to the therapist that her hand "and neck pain" was not as bad today. (Px#2) On a return visit with Dr. Levi on September 10, 2014, he noted that the cervical MRI demonstrated a 4-5mm disc herniation indenting the thecal sac on the left side at C5-C6. (Px#2) Another less prominent disc herniation was observed at C4-C5. At that visit, Dr. Levi indicated that the Petitioner does not have neck pain. Dr. Levi concluded that the cervical disc herniations were not the source of her problem. He performed an injection into the right wrist to help relieve her CTS symptoms. The Petitioner was still receiving physical therapy.

On September 15, 2014, the claims adjuster mailed a denial of claim letter to Dr. Levi. (R Group #19) Dr. Levi and the Petitioner did not utilize her group health insurance plan. The Respondent continued providing health insurance coverage through October 1, 2014. (Rx#8 and Rx#9) The Petitioner obtained her own independent health insurance and continues to have coverage today; however, no attempt was made to utilize her health insurance for her treatment with Dr. Levi.

On October 1, 2014, Dr. Levi recommended surgery for the left wrist to address her left-sided CTS and de Quervain's tenosynovitis. (Px#2) On October 28, 2014, CCMSI sent a second denial of claim letter to Dr. Levi. (Rx#19) On November 5, 2014, Dr. Levi commented that "we are waiting for an approval from the insurance company" for surgery. (Px#2) On December 3, 2014, Dr. Levi stated in his progress note that the Petitioner's condition is due to her computer work and needs surgical intervention; however, no surgery was scheduled because "we don't' have insurance approval." The claims adjuster then sent a third denial of claim letter to Dr. Levi on December 9, 2014 and urged him to use health insurance. (Rx#19) Despite the three denial letters, Dr. Levi again indicated "we are waiting for an approval" on January 14, 2015. The records reflect that Dr. Levi continued to treat the Petitioner with therapy, injections, and medication management for a period of two years until he finally performed surgery on the left wrist on January 28, 2016. (T.50-51) St. Francis Hospital processed its surgery bill through the Petitioner's health plan. (Px#14) While waiting for her surgery, the records also reflect that the Petitioner exhibited a positive Finkelstein's test in her "right" wrist for the first time on March 18, 2015. (Px#2 and Rx#17) The Petitioner continues to treat with Dr. Levi and surgery is recommended for the right side. The Petitioner has been unable to undergo surgery for the right side.

On cross-examination, the Petitioner denied placing her two computer monitors on top of the packaged copy paper. (T.67-68). She also denied that she could have removed the packages of copy

paper if she so desired, testifying that removing the copy paper packages from beneath her monitors "was not an option given to us." (T.68-69) The Petitioner then conceded that no one told her she could not remove the copy paper packages. (T. 69) Nevertheless, the Petitioner agreed that the height elevation of her monitors would only affect the direction of her eyes, with her eyes looking higher if the monitors were higher and looking lower if the monitors were situated lower. (T.68-69) The Petitioner agreed that the positioning of her monitors did not affect her hands. (T.69-70) The Petitioner testified that the handrest pad was situated adjacent to her keyboard for her to rest her wrists while typing. (T. 70) The Petitioner further agreed that the chair shown in the photo of her work station was the chair she used. (T. 70)

On further questioning, the Petitioner testified that the medications she was prescribed had been dispensed at Dr. Levi's office. (T. 72-73) These medications were billed separately through an entity called Developmental Pharmaceutical Management with charges of $51,447.46. The Petitioner also testified that all of the physical therapy she received was provided at Dr. Levi's office. (T. 72-73)

The Petitioner testified she had group health insurance coverage when she began treating with Dr. Levi. (T.81) The Petitioner believed that Dr. Levi had her policy information when she made her first appointment. (T. 82-83) The Petitioner agreed she received a denial of claim letter from the workers' compensation adjuster. (T.83-84) The Petitioner recalled that her group health insurance ended on or around October 1, 2014. (T.97-98) She agreed that she had health insurance available from the first date she saw Dr. Levi on May 30, 2014 through October 1, 2014, a period of four months. (T. 98) Thereafter, the Petitioner procured "Obamacare" health insurance using the State's exchange which she has maintained through the date of trial. (T. 98-99)

Regarding her employment duties, the Petitioner testified that the Respondent has a well-established customer base and the company's customer-data is stored in its computer system. (T. 88-89) The Petitioner testified that her computer screens consisted of boxes where the Petitioner would click with a computer mouse to bring up information for selection. (Rx#1, T. 90-91) The Petitioner testified she is right-hand dominant and she used her right hand for mouse clicking. (T. 91) Once clicked, a drop-down menus open up with lists of options. (T. 92) The Petitioner agreed she would then click on an option and the selected information would automatically get plugged into the system. (T. 92) The Petitioner testified that the mouse clicking was repetitive; however, she also testified that she used her right hand for clicking. (T. 94-95) As for the international customers she handled, the Petitioner testified that those customers submitted their purchase orders through a system called EDI. (T.86) For purchase orders placed through the EDI system, the Petitioner needed only to verify "everything lined up correctly." (T. 87) The Petitioner agreed that purchase orders placed through the EDI system are already filled out and it was her responsibility to review the orders for completeness and accuracy. (T. 87) The Petitioner further agreed that no data entry is needed for the international accounts unless corrections were necessary. (T. 87) In addition to entering data, the Petitioner also received phone calls which included taking customer orders and answering questions. (T. 93-94) If there was a question regarding status of a prior purchase, the Petitioner needed to simply click on the order to look up the information. (T.94) The Petitioner did not type long letters or memoranda for the Respondent. (T. 20). Her job function was to enter data into the computer system and occasionally she would draft emails. (T.89-90)

On re-direct examination, the Petitioner reiterated that she spent 90% of her time using the computer keyboard. (T. 104) She also testified that no one ever taught her how to perform her job properly before she started having pain. (T. 105)

Testimony of Doug Cunningham

Doug Cunningham testified on behalf of the Respondent. Mr. Cunningham is the company's vice president and has been employed with the Respondent for 18 years. Mr. Cunningham previously held the title of vice president of administration and information until three years ago when another vice president retired, upon which he assumed a larger role. (T. 114-115) Mr. Cunningham testified that the Respondent manufactures hand tools, the majority of which are hex keys (also known as Allen wrenches), and which the Respondent sells to industrial companies and retailers. On the retail side, the Respondent sells to large retail chains such as True Value, Menards, and Ace Hardware. On the industrial side, the Respondent sells to companies such as Grainger and McMaster-Carr. The Respondent currently employs 115 workers. The Petitioner worked in the office area which was separate from the manufacturing area. Mr. Cunningham testified that the Respondent employed seven office workers at the time of the Petitioner's departure from the company. (T. 117)

Mr. Cunningham testified that the Petitioner began working for the Respondent in 2008 and held the title of customer service representative. The Petitioner's job functions included processing purchasing orders on her computer, responding to customer inquiries, making sure product was shipped on time, and ensuring that the customers' needs were met. (T. 117) In addition to processing purchase orders, the Petitioner's other activities involved answering incoming customer orders received via fax or email, taking orders over the phone and answering questions, and dealing with people who came in the door. (T. 118-119) Mr. Cunningham further testified that the computer work involved a combination of keyboarding and clicking with the mouse. (T. 132-133) Mr. Cunningham testified further that the Petitioner was never required to type long letters or reports. (T. 122-123). Mr. Cunningham testified that he and other management employees typed their own reports and correspondence. (T. 123) Mr. Cunningham testified he has worked in the manufacturing sector since he completed college in 1987, and over his 30-year career, he has worked for two companies involving assembly operations. (T. 182) Mr. Cunningham testified he is familiar with jobs requiring repetitive use of the hands; the Respondent's assembly workers are required to assemble between 94 and 120 sets per hour. (182-183) Mr. Cunningham testified further that the Respondent's assembly workers are generally making the same tool over and over again with their hands. (T. 187) The Respondent's office staff, on the other hand, performs a variety of different jobs (T. 187)

Mr. Cunningham further testified that the pace of the work depended on the level of business, with some days being quite slow. (T. 119-120) Describing the work environment, Mr. Cunningham testified that the workplace was casual and laid back, and while the Respondent expected its workers to get their work done, the company did not stand over them and there was no quota regarding the number of purchase orders processed. (T. 120, 122) Addressing the extent of the computer use, Mr. Cunningham testified further that the computer keyboarding was very intermittent. (T. 120-121) Sometimes, the computer work involved responding to emails; however, the processing of purchase orders involved mostly mouse clicks rather than actual keyboard typing. (T. 121) Mr. Cunningham testified that the computer screens were designed with fields and drop-down menus to limit typing as much as possible for quality control purposes. (T. 121) By eliminating the need for employees to "free format" the data-entry, the Respondent was able to reduce the risk for mistakes. (T. 121) By way of example, when the customer name comes up, the system generates a list of the available "ship-to locations" to avoid delivery errors. Additionally, pricing also comes up automatically. (T. 121-122)

Referring to Respondent's Exhibit #1, Mr. Cunningham testified that the photo of the Petitioner's computer monitors displayed the system's interface when entering purchase orders. (T. 124) Mr.

Cunningham further identified Respondent's Exhibit #2 as screenshots of the computer's customer order entry program. (T. 134) The exhibit contains one of the computer screens on page one and two more screens on contained on page two. (T. 134) Mr. Cunningham testified that the Respondent has used this program since 2004 and this was the only program used by the Petitioner during her period of employment. (T. 134-135) Mr. Cunningham then described the steps for processing an order. When an order is received, a box marked order number comes up and the Petitioner would then use the mouse to click on the arrow to enter the purchase order number, which brings up on the screen the purchase order which the program has already prepopulated with information. The Petitioner next enters the customer's purchase order number and the zip code for the destination. After entering those two items, a list of the potential matches for delivery locations comes up, at which point the Petitioner then double-clicks on one of the addresses with the mouse. When the address location is clicked, the program's next screen comes up. Referring to page 2 of Exhibit #2, Mr. Cunningham testified that the next screen is almost completely prepopulated with information based on the prior data just entered. The Petitioner would next enter the name of the person who placed the order and then click on a drop-down box adjacent to the ship-to location to determine how the product is to be shipped. The next screen then comes up and the Petitioner must enter the product information which requires a product number and quantity. Mr. Cunningham also testified that pricing comes up automatically. The Petitioner would enter a "line" for each product item which typically varied from one to ten lines with some orders occasionally involving as high as 150 product items. (T. 137) The system then asks the customer service representative to re-enter the part numbers and quantities a second time for verification purposes. (T.137-138) Referring to Respondent's Exhibit #2, Mr. Cunningham testified that boxes highlighted in yellow represented the fields where the Petitioner would enter information, be it clicking with a mouse or entering some data. (T. 139-140) The arrows designate the location of the drop-down boxes for mouse-clicking. (T. 140, 141) The remaining boxes are fields where the information auto-populates. (T. 140, 141-142)

Mr. Cunningham also testified that the Petitioner handled the Respondent's largest accounts, such as Ace, True Value, and Grainger. Those customers transmit their orders using a system called the electronic data interchange or "EDI." (T. 118) Mr. Cunningham explained that customers using the EDI enter purchase orders themselves and transmit the orders electronically. (T. 118) As such, the customer service representative was only required to verify the orders when received over the EDI. (T. 118) Mr. Cunningham described the EDI system as similar in concept to ordering pizza for delivery online instead phoning in the order; however, the EDI purchase orders do not go through the internet. (T. 146) The Respondent's larger customers upload their purchases and the orders are electronically transmitted and received by the Respondent. With orders transmitted over the interchange, there is no need to enter the data into the Respondent's computer. (T. 146) None of the computer screens need be completed for EDI orders as all the information is auto-populated. (T. 147) The Customer Service representative's function when receiving orders over the EDI is limited to reviewing the information for accuracy. (T. 147) If a part number was incorrectly entered by the customer, then the customer service representative would make that correction. Mr. Cunningham further testified that the Petitioner was the only customer service representative who primarily handled EDI orders because the Respondent's best customers used the EDI system and the Petitioner had a "well-trained eye" for that task. (T. 147) Mr. Cunningham testified further that the Petitioner did not have much computer entry work for the orders transmitted over the EDI. (T. 147-148)

In response to the Petitioner's testimony concerning paperwork, Mr. Cunningham testified that there are a variety of different forms, some of which are required by the customers and some of which

are required by the shipping companies. (T. 191) Mr. Cunningham testified further that those forms are in the computer system and the Petitioner was only required to enter data into certain fields and the system would then complete the forms. (T. 191)

Regarding the work stations, Mr. Cunningham testified that the chairs were getting old; however, he denied that the chairs presented any issues for its workers or the Petitioner. (T.124-25) Mr. Cunningham testified that the Respondent had decided to replace them in 2014 due to a pending office relocation, but there was nothing substandard about the chairs. (T. 125) The relocation of the office staff had nothing to do with the Petitioner's claim and was decided months earlier. (T. 127) In preparation for the relocation, he sent out an email regarding the planned arrival of Ms. Meredith Wayant. Ms. Wayant works for CCMSI. (T. 127-128) According to Mr. Cunningham, Ms. Wayant came out to visit the company on a quarterly basis each year in March, June, September and December. (T. 128) Since the company was relocating its office staff, it was decided that Ms. Wayant would look at the office area. Mr. Cunningham testified further that Ms. Wayant became aware of the Petitioner's claim because he made her aware of it; however, her visit was set up months ahead of time. (T. 129) Mr. Cunningham also testified that there had been no complaints made by anyone about the office furniture or about the ergonomics of the work stations. (T. 130)

Regarding the Petitioner's testimony that she had never received any kind of ergonomic training as to how to safely and properly position herself, Mr. Cunningham stated that the Petitioner's testimony was incorrect. As part of the claims administration services provided by CCSMI, representatives come by to visit the company on a regular basis, and ergonomics training was provided to the office staff in 2010 and the attendees all signed a document to document their training. (T. 130-131) Mr. Cunningham identified Respondent's exhibit #20 as a form the Respondent used to obtain the attendees' signatures to document their training in 2010. (T. 131) The document is captioned "Office Ergonomic Training" and identifies Dennis Coleman from CCMSI as the trainer. The document is dated November 17, 2010 and contains a list of employees and their signatures. Mr. Cunningham identified the Petitioner's signature. (T. 131, Rx#20)

The Respondent also offered into evidence a document setting forth a three-month period of purchase orders entered by the Petitioner between March 3, 2014 through June 3, 2014. (Rx#3, T. 150) Mr. Cunningham testified he retrieved this data for trial and identified the columns of data shown on the exhibit. (T. 150-154) The data documents the amount of purchase orders the Petitioner entered each day. For example, the Petitioner processed seventeen customer orders on March 3, 2014. (T. 153) On March 6, 2014, the Petitioner processed nineteen orders. Mr. Cunningham also explained that the column "line number" shows the number of product items purchased with each customer order. (T. 154) The vast majority of the orders consisted of purchases ranging from 1 to 12 products. On an intermittent basis, the Petitioner entered larger orders for bulk purchases during this three-month period of 192 items, 224 items, 85 items, 90 items, and 138 items. Mr. Cunningham testified that when multiple product items were purchased at one time by a customer, the customer service representative would only need to enter the part number and quantity for each item. (T. 155) The remaining portions of the fields in the computer screens would involve the same steps as he described earlier. (T.155-156)

On cross-examination, Mr. Cunningham clarified that Respondent's Exhibit #3 only documents the purchase orders processed by the Petitioner and does not document orders transmitted over the EDI. (T. 227) Mr. Cunningham testified that EDI orders, which are completed by the customers themselves before transmission, are not recorded. (T. 228) Respondent's Exhibit #3 represents a three-month sample of the orders the Petitioner herself actually entered into her computer. (T. 228) Mr. Cunningham reiterated that the Petitioner was only responsible for verifying the accuracy of the orders

made over the EDI. (T.228) While reviewing all the EDI orders, the Petitioner was responsible for making corrections when needed; however, those situations were rare. (T. 228) Mr. Cunningham further pointed out that the Petitioner handled the large accounts such as Ace Hardware, Grainger, Snap-On, and True Value. (T. 228) Mr. Cunningham agreed that the Petitioner worked at her desk about 85% to 95% of the workday. (T. 211) Mr. Cunningham further testified that the Petitioner was also responsible for making sure the production department knew about the orders and making sure the orders shipped out on time. (T.228) Mr. Cunningham further stated that those job duties "takes time." (T. 228) As explained by Mr. Cunningham, much of the work performed by the Petitioner was "visual" which is time-consuming. (T. 229)

On re-direct, Mr. Cunningham further testified that the Respondent's largest customers placed their orders over the EDI and typically contain "a lot of lines" (product items per order). (T. 235) For example, Grainger could transmit up to nine different purchase orders at one time and each order could involve 50 to 75 lines of product items. (T.235) The purchase orders transmitted over the EDI did not require computer data-entry by the customer service representative; it only needed to be reviewed and verified for accuracy. (T. 235) In short, the Petitioner's job entailed a lot of reading. (T. 235)

Testimony of Dr. Roberto Levi

Dr. Levi is a board certified orthopedic surgeon providing treatment and surgical intervention in the care of joint and muscle disorders. Dr. Levi testified he treats patients with carpal tunnel syndrome on a weekly basis. Dr. Levi testified there are many known causes for carpal tunnel syndrome, the most common of which are diabetes, fractures, rheumatoid arthritis, repetitive motion, and using vibratory tools. (Px#3 at 7) Dr. Levi further testified that sometimes physicians are unable to determine the origin for this condition. (Px#3 at 7) Dr. Levi also treats de Quervain's tenosynovitis, which he defined as a similar compression type condition involving the tendons attached to the thumb. (Px#3 at 7-8) Dr. Levi testified that the most common causes for de Quervain's include trauma, inflammatory disease and repetitive motion.

Dr. Levi testified that he initially evaluated the Petitioner on May 30, 2014. The Petitioner complained of bilateral wrist pain and numbness in the territory of the median nerve with a history of working with computers for the past six years. Dr. Levi testified his examination revealed a positive Phalen findings bilaterally and a positive Finkelstein's finding on the left side. (Px#3 at 10) Dr. Levin explained that the Phalen's test will reproduce numbness in the thumb, index, middle and ring fingers in patients with compression of the median nerve. (Px #3 at 10-11) Dr. Levi further testified that the Finkelstein's test is designed to apply tension on the tendons and will reproduce pain in patients with de Quervain's tenosynovitis. (Px #3 at 11) Dr. Levi testified it was his impression that the Petitioner had bilateral carpal tunnel syndrome and left-sided de Quervain's tenosynovitis. (Px#3 at 10)

Dr. Levi testified he recommended an EMG test for both upper extremities which demonstrated normal findings. Dr. Levi testified that a positive EMG result can be used to corroborate the diagnosis; however, a negative test does not necessarily rule out the condition. Dr. Levi ordered a second EMG test with a different examiner and that test was also negative for carpal tunnel syndrome. (Px#3 at 14-15) Dr. Levi testified that the repeat test showed evidence for cervical radiculopathy; however, the Petitioner did not have neck pain and the EMG result was not consistent with her symptomology. Dr. Levi ordered a cervical MRI which demonstrated a disc herniation at C5-C6; however, Dr. Levi noted that the MRI showed a left-sided disc herniation whereas the Petitioner's symptomology was bilateral. (Px#3 at 17) Dr. Levi continued to diagnose carpal tunnel syndrome and de Quervain's tenosynovitis. Dr. Levi provided physical therapy, analgesics, anti-inflammatories, and injections. Dr. Levi testified he performed an injection into the right carpal tunnel in September, 2014, followed by an injection into the left carpal tunnel in December, 2015. (Px #3 at 18-19) Dr. Levi testified that the injections provided minimal relief. Dr. Levi further testified he performed a carpal tunnel release and a de Quervain's

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release on January 28, 2016 for the Petitioner's left wrist. (Px#3 at 20) Dr. Levi testified that the left-sided surgery provided significant relief to the Petitioner's symptoms; however the Petitioner continued to have numbness in the territory of the superficial nerve, a branch of the radial nerve. (Px #3 at 22) Dr. Levi testified he then recommended surgery for the right hand.

Regarding the Petitioner's occupation, Dr. Levi testified it was his understanding that she was working with computers all the time. Dr. Levi further testified that he reached a causation opinion during his initial evaluation. (Px#3 at 12) Dr. Levi testified that computer work is a very common cause for both CTS and de Quervain's. (Px#3 at 12) In his opinion, the Petitioner's bilateral carpal tunnel syndrome and left-sided de Quervain's was causally related to her occupation. (Px#3 at 12-13) Dr. Levi further testified he was waiting for approval for the right-sided wrist surgery which never came. (Px#3 at 23) Dr. Levi testified that he last saw the Petitioner on January 11, 2017.

On continuing direct examination, Dr. Levi was asked if the Petitioner ever exhibited any signs for de Quervain's syndrome on the right side. Dr. Levi stated he did not think so and needed to review his notes. (Px#3 at 22) Dr. Levi then testified that at some point in time he eventually diagnosed de Quervain's syndrome on the right side. (Px#3 at 24) Dr. Levi further testified that added de Quervain's release to his previous recommendation for a carpal tunnel release for the right side. (Px #3 at 25) Dr. Levi testified that the first documented finding for right-sided de Quervain's occurred in March, 2015; however, he also testified that the Petitioner had been complaining of right-sided symptoms of de Quervain's syndrome even though he never documented those symptoms. (Px#3 at 26) Dr. Levi further opined that the bilateral de Quervain's was also causally related to the Petitioner's computer use. He based this opinion on his belief that the Petitioner used her thumbs to hit the bar while keyboarding for hours on a daily basis. (Px #3 at 26)

Dr. Levi disagreed with Dr. Biafora's opinion that force is required in order to develop carpal tunnel syndrome and de Quervain's tenosynovitis from repetitive use. (Px#3 at 27) Dr. Levi further testified that the mechanism of injury in carpal tunnel syndrome in relation to computer keyboarding is the position of the wrists over a period of many years. (Px#3 at 28) According to Dr. Levi, depending on the angle of the wrists, computer use can be a cause for carpal tunnel syndrome and de Quervain's tenosynovitis. (Px #3 at 28)

Dr. Levi also testified that the Petitioner worked light duty with a brace for a period of one month, after which he placed her on off work restrictions beginning in late June, 2014. (Px #3 at 28-29) Dr. Levi testified he is continuing to keep the Petitioner off work until he is able to perform surgery on the right side. Returning to the issue of causation, Dr. Levi testified that the Petitioner does not have any other significant risk factors such as diabetes. When asked about her weight, Dr. Levi testified that the Petitioner's weight is "nothing spectacular, practically a normal lady." (Px#3 at 33)

On cross-examination, Dr. Levi testified he practices medicine with a group called Orthopedic and Rehabilitation Centers. (Px#3 at 35) Dr. Levi further testified that he is the founder and owner of this medical group. Dr. Levi denied advertising medical treatment services for workers' compensation patients. (Px#3 at 35) Dr. Levi then admitted to having a website on the internet and modified his previous answer, stating that he does not advertise on the radio, except last year he advertised on the radio during Chicago White Sox games. (Px#3 at 35-36) On further questioning, Dr. Levi agreed that his website states his medical group is highly experienced in dealing with workers' compensation injuries. His website also states that his medical group provides treatment services with a "commitment" to patients with work related injuries. (Px#3 at 36) Dr. Levi further agreed that his website describes the services his clinic provides for patients in the workers' compensation system, including the providing work status notes when needed. (Px#3 at 36-37)

Regarding the history obtained from the Petitioner, Dr. Levi was unable to recall whether he ever reviewed a written job description and he was unaware of the Petitioner's job title. (Px#3 at 48) Dr. Levi testified he did not know the nature of the Respondent's business and his testimony reflected that he did not have any understanding as to the Petitioner's job functions other than it involved computer typing. (Px#3 at 49) On further questioning, Dr. Levi was unable to state what types of information the Petitioner was typing into the computer. (Px#3 at 50) When asked if it matters for causation purposes whether a worker is performing a lot or a little typing during an eight-hour workday, Dr. Levi testified

that he has seen patients in the past who worked for only three weeks on computers and had to stop working because of carpal tunnel syndrome after never having had a problem before. (Px#3 at 51) When asked if it makes a difference whether a worker is also answering phones during portions of the day, and whether it would make any difference whether a worker's keyboarding is 10% of the day, 20%, 40% or more, Dr. Levi testified that employees who devote 100% of their day answering phones can also develop carpal tunnel syndrome because of the position of the hand while grabbing the phone on the desk. (Px#3 at 53) When asked if it makes a difference whether an employee is performing computer typing for 5% or 80% of the day, Dr. Levi then admitted that it would make a difference, stating that using the computer would probably not be a cause if the worker is almost never on the computer. (Px#3 at 55) Dr. Levi agreed that his causation opinion is based on the information provided to him by the Petitioner. (Px#3 at 55)

On further cross-examination, Dr. Levi agreed that carpal tunnel syndrome can develop from a variety of causes that are not occupationally related. (Px#3 at 61-62) He agreed that gender is a risk factor because females more commonly than males develop carpal tunnel syndrome. (Px#3 at 62-63) Dr. Levi further agreed that obesity is a risk factor; however, when asked about the Petitioner's height and weight, Dr. Levi admitted that he did not obtain that information from the Petitioner. (Px#3 at 63) Nevertheless, Dr. Levi testified he remembered the Petitioner perfectly and indicated that the Petitioner was not overweight. (Px#3 at 63) Dr. Levi agreed that many patients can develop carpal tunnel syndrome ideopathically. (Px#3 at 64-65)

Testimony of Dr. Sam Biafora

Dr. Sam Biafora is a board certified orthopedic surgeon with a subspecialty certificate in hand surgery. (Rx#14 at 4-5) Dr. Biafora testified he performs multiple hand and wrist surgeries on a weekly basis. (Rx#14 at 6) After medical school and completing his residency, Dr. Biafora completed a hand and upper extremity fellowship at the Philadelphia Hand Center at Thomas Jefferson University. (Rx#14 at 6-7) Dr. Biafora performed a Section 12 evaluation at Respondent's request on July 31, 2014.

Dr. Biafora testified that the Petitioner complained of a four to five-month history of bilateral numbness and tingling in the hands and a two to three-month history of left radial-sided wrist pain. (Rx#14 at 9) The Petitioner reported having received one month of physical therapy and undergoing a nerve study. (Rx#14 at 9) The Petitioner further reported working in data entry for the past six years. The Petitioner stated she performed computer keyboarding throughout her workday and used a mouse with her right hand. (Rx#14 at 10) The Petitioner also reported she had been off work since June 20, 2014. On physical examination, the Petitioner exhibited positive Tinel's findings and median nerve compression findings in both hands. (Rx#14 at 11) On the left side, the Petitioner also exhibited tenderness over the first extensor compartment with a positive Finkelstein's test. (Rx#14 at 10-11) The left wrist also exhibited mild pain with resisted thumb extension over the first extensor compartment. Dr. Biafora further testified that the Petitioner presented with a height of 5ft 7in and a weight of 200 pounds. (Rx#14 at 11)

Dr. Biafora testified he reviewed the results of an EMG test which had been performed on June 13, 2014, and showed normal findings for both hands. (Rx#14 at 12) Dr. Biafora opined that the Petitioner suffered from bilateral hand numbness and tingling with left-sided de Quervain's tenosynovitis. (Rx#14 at 12) Dr. Biafora testified that the bilateral numbness and tingling were suspicious for possible carpal tunnel syndrome, which could not be confirmed due to the negative EMG test. (Rx#14 at 12-13) Dr. Biafora further testified that it is possible for a patient to have carpal tunnel syndrome with a normal EMG finding. In those situations, the carpal tunnel syndrome would be very mild. (Rx#14 at 13) Dr. Biafora testified that de Quervain's tenosynovitis is an inflammation and swelling of the extensor tendons of the first compartment on the thumb-side of the wrist. (Rx#14 at 14) Dr. Biafora further testified that there was no evidence for right-sided de Quervain's at the time of his

examination in July, 2014. Dr. Biafora further testified there was also no evidence in the medical records for de Quervain's in the Petitioner's right wrist. (Rx #14 at 14)

Addressing the issue of causation, Dr. Biafora opined that the Petitioner's bilateral hand numbness or carpal tunnel syndrome was not related to her computer use at work. He further opined that her left-sided de Quervain's was unrelated to her work activities. (Rx#14 at 17) In support of his opinion, Dr. Biafora testified that carpal tunnel syndrome most commonly occurs without any known cause. (Rx#14 at 18) Dr. Biafora further testified that there are activities which may contribute to carpal tunnel syndrome, but those activities involve force and repetition such as gripping activities. (Rx#14 at 18) Dr. Biafora testified further that repetition alone would not cause carpal tunnel syndrome; force is required for activity-based carpal tunnel syndrome. (Rx#14 at 18)

Dr. Biafora also opined that the Petitioner's left sided de Quervain's tenosynovitis was not related to her computer use, explaining that tendinitis requires force in order to causally relate the condition to one's occupation. (Rx#14 at 18) Dr. Biafora further testified that the tendons in question are located on the thumb side of the wrist and insert near the base of the thumb. According to Dr. Biafora, activities which involve forceful pinching or forceful deviation of the wrist can contribute to de Quervain's tenosynovitis. (Rx#14 at 19) Repetitive activities alone without application of force would not cause or contribute to de Quervain's tenosynovitis. (Rx#14 at 19) By way of example, Dr. Biafora described the wrist motion a carpenter makes while gripping a hammer throughout the day. (Rx#14 at 19) Dr. Biafora further testified that computer keyboarding does not utilize back and force wrist deviation. (Rx#14 at 20) Dr. Biafora also testified that his opinion would remain unchanged even if a worker performed computer keyboarding on a repetitive basis throughout the workday over a prolonged period of time such as years of employment. (Rx#14 at 20-21) Dr. Biafora did testify that it is possible that with any type of activities during the day symptoms may manifest themselves, but it doesn't mean that if one has a manifestation of symptoms while engaged in an activity that the activity is causing or aggravating that condition. (Rx#14 at 20-21)

Dr. Biafora performed a second medical evaluation on January 19, 2017, at which time he obtained updated treatment history. The Petitioner reported she had received injections which resulted in temporary improvement, after which she underwent a left carpal tunnel release and de Quervain's release in January, 2016. The Petitioner further reported attending a post-operative course of physical therapy over a period of three months. The Petitioner's left-sided numbness and pain ultimately resolved following the surgery; however, she continued to experience some tingling in her left index and middle fingers with mild tingling over the radial aspect of the hand near the thumb and index web space. The Petitioner further complained of ongoing numbness in all her fingers on the right side. Her physician was recommending surgery for the right wrist. The Petitioner reported she had been off work since June 20, 2014, having been placed off work by her treating physician. She further advised Dr. Biafora that she had resigned from her employment in August of 2016. The Petitioner indicated her weight was 200 pounds. Dr. Biafora testified her BMI was 31. (Rx#14 at 27) Dr. Biafora testified that the cutoff for obesity is a BMI of 30. Dr. Biafora further testified that his updated examination revealed a positive Tinel's finding and an equivocal median nerve compression test bilaterally, right greater than left. (Rx#14 at 28)

Dr. Biafora reviewed updated medical records which included a repeat EMG test result from July 25, 2014. Dr. Biafora testified that the second EMG test was negative for evidence of focal median nerve impingement or carpal tunnel syndrome. (Rx#14 at 29) The second EMG test did show evidence for bilateral cervical radiculopathy. (Rx#14 at 29) A cervical MRI had also been performed which demonstrated a left-sided disc herniation at C5-C6 with significant left-sided spinal stenosis and narrowing of the lateral recess. (Rx#14 at 30) According to the MRI report, the radiologist noted extruded nucleus pulposus.

Dr. Biafora further testified that the Petitioner was diagnosed with de Quervain's tenosynovitis on the right side during the intervening period between his two examinations. (Rx#14 at 30-31) Dr. Biafora reiterated his previous testimony that there were no documented complaints or medical findings consistent with right-sided de Quervain's in the medical records through the date of his first IME. Dr. Biafora testified that the right-sided de Quervain's tenosynovitis was documented for the first time in

Dr. Levi's records on March 18, 2015. (Rx#14 at 32) Dr. Biafora's second examination in January of 2017 also revealed clinical findings consistent with right-sided de Quervain's. (Rx#14 at 32) Dr. Biafora further noted that the first documented finding for right sided de Quervain's tenosynovitis occurred approximately eight months after the Petitioner discontinued working. (Rx#14 at 32-33) Dr. Biafora also testified that de Quervain's can also develop ideopathically for no known reason. (Rx #14 at 33)

Dr. Biafora testified that his prior causation opinions remain unchanged. (Rx#14 at 34) Dr. Biafora testified that the subsequent development of right-sided de Quervain's lends further support for his causation opinion. Dr. Biafora testified that the Petitioner, having developed de Quervain's several months after she had removed herself from her employment, establishes that the right-sided de Quervain's was not work-related. (Rx#14 at 35-36) Likewise, Dr. Biafora testified that the late development of right-sided de Quervain's while off work supports his opinion that the Petitioner's left-sided de Quervain's was also not work related. (Rx #14 at 35)

Further addressing the causes of carpal tunnel syndrome, Dr. Biafora testified there are several known risk factors or associated factors which correlate with the development of carpal tunnel syndrome. Dr. Biafora testified that those risk factors include age, female gender, thyroid disease, smoking, inflammatory arthropathies such as rheumatoid arthritis, and obesity. In this case, the Petitioner is at risk for carpal tunnel syndrome by virtue of her female gender and weight. (Rx #14 at 36-37) According to Dr. Biafora, women tend to develop carpal tunnel syndrome more often than men, and the difference between the female and male populations of carpal tunnel patients is statistically significant such that medical scientists have concluded that gender is a risk factor. (Rx#14 at 36-37) Testifying further, Dr. Biafora reiterated that the Petitioner's keyboarding activities were not forceful and that repetitive activities alone are insufficient to cause carpal tunnel syndrome. (Rx#14 at 37-38)

Regarding Petitioner's treatment, Dr. Biafora testified that as of the time of his second medical evaluation, it was his opinion that over-the-counter anti-inflammatories would be appropriate as needed. Dr. Biafora testified that stronger narcotic medication would not be warranted. (Rx#14 at 39) Dr. Biafora further testified that he did not disagree with Dr. Levi's medical treatment; however, it was his opinion that the physical therapy provided between July, 2014 and January, 2016 was excessive. (Rx#14 at 39) According to Dr. Biafora, when a patient initially presents with symptoms, it is reasonable to undergo therapy for a few weeks to a couple of months, but at some point the patient plateaus and it is obvious that the Petitioner in this case plateaued. Pre-operatively, physical therapy for a period of six to eight weeks was reasonable. (Rx#14 at 41) In Dr. Biafora's opinion, the Petitioner's physical therapy from July of 2014 through September of 2014 was reasonable. Conversely, the therapy she received from September 3, 2014 through January of 2016 was unreasonable. (Rx#14 at 41-42) Post-operatively, the therapy the Petitioner received was reasonable as of the time of his second evaluation. (Rx#14 at 42-43)

On cross-examination, Dr. Biafora testified he is not certified for performing Utilization Reviews and does not perform them. (Rx#14 at 48) Regarding the Petitioner's height and weight, Dr. Biafora testified he relied on the history as reported to him by the Petitioner herself. (Rx#14 at 49) In response to questions regarding the Petitioner's BMI score, Dr. Biafora testified that whether or not the Petitioner was below or above the BMI cutoff point would not affect his opinion. Dr. Biafora testified that being overweight is itself a risk factor even if they are at a lower BMI score. (Rx#14 at 49-50) Regarding his opinion that computer keyboarding is not a cause of carpal tunnel syndrome and de Quervain's tenosynovitis, Dr. Biafora agreed that doctors in his field can reasonably disagree on that issue. (Rx#14 at 52)

On further cross-examination, Dr. Biafora testified he was not aware of any complaints that the Petitioner may have had concerning her work station. (Rx#14 at 53) Dr. Biafora admitted he did not ask the Petitioner to describe her hand positioning while engaged in computer keyboarding. Dr. Biafora testified that significant wrist flexion could be a contributing cause; however, in order for the wrist to be sufficiently flexed, the keyboard would have to be at the user's chest level in order to create that degree of wrist flexion. (Rx#14 at 54)

On continuing cross-examination, Dr. Biafora was asked why he recommended the use of wrist splints for returning to work if computer keyboarding was not a causative factor. Dr. Biafora explained

that the purpose of the wrist splints is to minimize manifestation of symptoms while working; however, prescribing wrist splints is not inconsistent with his opinion. Elaborating further, Dr. Biafora testified he does not doubt that the Petitioner had complaints of numbness while working; however, people have symptoms related to carpal tunnel syndrome regardless of what they are doing throughout the day. (Rx#14 at 55) Dr. Biafora further testified that people can feel carpal tunnel symptoms while sleeping and wake up at night. However, that does not mean that sleeping causes carpal tunnel, and doctors prescribe splints for night time use.

On further questioning, Dr. Biafora testified he identified two risk factors which the Petitioner possessed for the development of carpal tunnel syndrome. When asked if there were any other potential risk factors, Dr. Biafora testified there is a medical study which correlates a history for hysterectomy with increased instance of carpal tunnel. However, Dr. Biafora indicated there was only one such medical study he was aware of, and for that reason he did not address that in his report. (Rx#14 at 57) According to Dr. Biafora, the Petitioner in this case did have a past history for hysterectomy. (Rx#14 at 57)

On re-direct examination, Dr. Biafora testified that a computer user's hands are safely positioned so long as the keyboard is at desk level near the user's abdomen. (Rx #14 at 62-63)

CONCLUSIONS OF LAW

In regards to issues C and F whether an accident occurred that arose out of and in the course of Petitioner's employment and whether is current condition of ill-being is causally connected to the injury; The Arbitrator finds as follows:

The Petitioner alleges that her work duties on her computer caused her to develop bilateral carpal tunnel and bilateral DeQiervain syndrome. The Respondent argues that the Petitioner has failed to prove a work accident and causal connection based on totality of the evidence and the medical opinions. The Arbitrator upon considering the testimony of the witnesses, the diverging medical opinions, finds that the Petitioner failed to prove she sustained a repetitive use injury that either caused or aggravated her bilateral carpal tunnel syndrome or bilateral DeQuervain's tenosynovitis. In reaching this conclusion the Arbitrator notes that medical opinion of Dr. Levi is that the Petitioner's repetitive computer work caused or worsened her condition. Dr. Siafora, the IME, found that repetition alone could not cause Petitioner's condition because her work activities did not involve force or repetitive gripping activities.

In order to evaluate the soundness of the medical opinions, the Arbitrator first examines the testimony of the Petitioner, Doug Cunningham along with photographic evidence of the Petitioner's work station.

The Arbitrator notes the testimony of the Petitioner as opposed to her employer, Doug Cunnigham, the Vice President of Ekling Tool Company. The Arbitrator notes that the Petitioner is a young, hard-working employee by all accounts. She began working for the Respondent as a customer service representative in 2008 and had been working for the company for over 6 years at the time of her accident. Her primary job duties included processing purchase orders on her computer, responding to customer inquiries and ensuring that orders were shipped out on time. Petitioner was also tasked with responding to customer needs via fax, email, phone or dealing with walk-ins. Petitioner's work on her computer involved both typing on a keyboard as well as using the mouse and the drop-down menu to process orders. Although the amount of computer work varied day to day, it is evident that Petitioner did spend a majority of her time on the computer. The Petitioner testified that she spent 90% of her

time on the computer keyboard. Mr. Cunnigham testified that Petitioner's work environment was casual and that although Petitioner did process work orders on her computer, a majority of that work involved checking the work orders and clicking on the 'drop-down' menus rather then "free format" entering the work orders. He disagreed that Petitioner spent a majority of her time typing on the keyboard. The Petitioner agreed that most of customer orders placed through the EDI system were pre-loaded and only needed verification and a check for accuracy by her. She testified that she is right hand dominant and used her right hand to click the mouse. She did not often type letters but would answer emails.

As to the work station ergonomics, the two witnesses also gave slightly contradicting testimonies. The Petitioner stated that her work chair could not be adjusted, was uncomfortable and her computer monitors rested on bulk copy paper to give them some elevation. She also stated that her hands were positioned at 30 to 40 degree angle when typing and that she was equipped with a soft hand-rest for her wrists. Mr. Cunningham agreed that the office chairs were old but he said there had been no complaints made by anyone in regards to the furniture or the ergonomics of the work station.

Initially, the Arbitrator notes that testimony of both individuals is crucial and valuable in assessing the true nature of Petitioner's work duties. The Arbitrator finds that the Petitioner probably does spend a majority of her time at her work-station and on the computer but that she does not necessarily spend 90% of the time typing on the keyboard. Per the descriptions of the various other job requirements and based on the fact that data-entry involved entering information into boxes or fields on various screens, with much of the information selected through drop-down menus and mouse-clicking the available options, Petitioner's time is devoted to many tasks. The evidence shows that the information entered to process a purchase order was limited as the software program auto-populated most of the purchase order information while the Petitioner entered the order. Further, the actual data entry work was limited to those customers who called or faxed in their purchase orders. The Respondent's larger customers transmitted purchase orders over the electronic data interchange, or EDI system. The purchases placed over the EDI were completed by the customers when transmitted; the Petitioner was only required to review those orders for accuracy and she performed data-entry on the EDI orders on rare occasions to correct errors. Doug Cunningham testified that the computer screens were designed with fields and drop-down menus to limit typing as much as possible for quality control purposes. By eliminating the need for employees to "free format" the data-entry, the Respondent was able to reduce the risk for mistakes. Mr. Cunningham also testified credibly that the Petitioner's computer typing was intermittent. The utilization of a software program designed to minimize typing is significant. Based on this testimony, the Arbitrator concludes that the Petitioner probably did spent 90% of her work-days at her computer; however, the actual amount of keyboarding was much less as the Petitioner's job function with respect to the larger orders transmitted over the EDI was mostly visual.

As to the ergonomics of her work station, the Petitioner testified that he had use of a soft wrist-rest when typing but that her hands were 30 to 40 degree angle to the computer. Respondent's Exhibit 1 does not bear this out. Petitioner's testimony regarding using a stack of copy paper as well as lack of proper training is credible but does not show that the ergonomics were adversely effected. The Petitioner also attributes her bilateral hand conditions to deficiencies with her workstation, the chair and the angle of her hands. The photographic evidence does not bear this out and Dr. Levi does not account for these factors in his causation opinion. Based on the photographic evidence of the work station and the Petitioner's testimony, the Arbitrator is hard-pressed to find that the ergonomics contributed to the Petitioner's condition.

In addition to the witness testimony, the Arbitrator evaluates the testimony of the treating physician, Dr. Levi and the IME, Dr. Biafora. Both physicians have outstanding credentials and did a

thorough examination of the Petitioner, including evaluating the EMG results. In the Arbitrator's opinion, their disagreement over the issue of accident and causal connection stems from whether Petitioner's keyboarding or other data entry duties (clicking on the mouse) can cause bilateral cause carpal tunnel or bilateral DeQiervain syndrome. The Arbitrator finds the testimony of Dr. Biafora to be more credible for the following reason:

Dr. Biafora's explained that carpal tunnel syndrome most commonly occurs without any known cause but that there are activities which may contribute to carpal tunnel syndrome. Dr. Biafora testified further that repetition alone would not cause carpal tunnel syndrome; force is required for activity-based carpal tunnel syndrome. Dr. Biafora further testified that there are activities which may contribute to carpal tunnel syndrome, but those activities involve force and repetition such as gripping activities. Petitioner testimony of her work description does not show use of force or a repeated gripping activity.

The Arbitrator has given more weight to his opinion because Dr. Levi's causation opinion given after the initial office visit lacked any detailed information or accounting of Petitioner's actual work duties i.e description of her work day, the time, duration spent on the keyboard, the nature of her work station. Dr. Levi also fails to explain away the impact of other factors that cause or contribute to the CTS. Additionally, an accounting or explanation regarding lack of use of force, lack of gripping motion and the time spent using the mouse as opposed to a keyboard could have greatly bolstered and strengthened Dr. Levi's findings. His medical findings fail to establish causation. He simply determined that the Petitioner's employment caused her CTS because the Petitioner reported performing computer work for six years. Dr. Levi acknowledged that gender and weight are known risk factors and he also agreed that patients can develop CTS idiopathically. His causation opinion failed to explain why Petitioner's symptoms were work related.

Therefore, in weighing the two opinions, the Arbitrator is cognizant that Dr. Biafora is the IME doctor and that his contact with the Petitioner is limited compared to the treating physician. However, the Arbitrator notes that Petitioner uses the mouse as well as the keyboard and that there is little evidence of any forceful gripping/grasping and/or significant vibratory impact which present the greatest risk factors associated with occupational CTS. Absent clear evidence of ergonomic issues or a more comprehensive treating medical provider opinion that matches/related these risk factors to Petitioner's work duties, the Arbitrator is disinclined to make a causal connection finding.

Ultimately, Petitioner DeQuervian syndrome diagnosis also supports Dr. Biofora's opinion that an ailment can be idiopathic and arise independent of the work duties. In this case, the Petitioner did not exhibit signs for DeQuervain's in the right wrist for eight months after she discontinued working for the Respondent. Additionally, despite her being right-hand dominant and using her right hand for mouse-clicking she has a late onset of this condition in her right hand. Given that DeQuervian develop ideopathycally, Dr. Biofora's opinion that the Left Hand's condition was unrelated is logical. The Arbitrator finds that Petitioner has failed to prove a causal connection regarding her DeQuervian symdrome.

In finally reaching her conclusion based on an analysis of the medical opinions, the Arbitrator also notes the facts in *Ramona Davis vs. Winnebago County States Attorney*, 14 IWCC 609, 2014 Ill. Wrk. Comp. 14 IWCC 609, 2014 Ill. Wrk. Comp. LEXIS 570. There this Commission noted as follows:

> "Petitioner's sedentary duties involve inputting data into the computer system, producing documents from forms and templates stored on the computer, reviewing files and making telephone calls. The letters she sends to witnesses are edited to reflect the correct names, dates, and relevant information. Petitioner did not testify that she types any documents

from start to finish, and there are no examples of any documents that Petitioner produced that are of any significant length."

In *Brandi Books v. Illinois-American Water, 16 IWCC 152, 2016 Ill. Wrk. Comp. LEXIS 201*

this Commission again notes the following regarding computer-related claims for carpal tunnel syndrome:

> "The Commission is not persuaded that work activities comprised of only substantial typing, using a computer mouse, and using a telephone with a headset significantly contributes to the development or aggravation of CTS.
> * * *
> Petitioner's activities do not include any forceful gripping/grasping and/or significant vibratory impact which are now considered the greatest risk factors associated with occupational CTS."

Therefore, based on the foregoing cases and analysis, the Arbitrator denies benefits as the Petitioner failed to sustain her burden of proving an occupationally related claim based on repetitive and long-term computer use.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph A. Cascio,

Petitioner,

vs.

NO: 15WC 18472

18IWCC0561

City of Rockford, Rockford, IL,
A Municipal Corporation, Fire Department,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 5, 2018 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.

18IWCC0561

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: SEP 18 2018
SJM/sj
o-8/30/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASCIO, JOSEPH A
Employee/Petitioner

Case# **15WC018472**

15WC017720
15WC020501

CITY OF ROCKFORD ROCKFORD IL A MUNICIPAL CORPORATION FIRE DEPT
Employer/Respondent

18IWCC0561

On 2/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% 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:

0529 TUITE LAW
GREGORY TUITE
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

18IWCC0561

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joseph A. Cascio
Employee/Petitioner

v.

Case # **15** WC **18472**

Consolidated cases: **15 WC 17720; 15 WC 20501**

City of Rockford, Rockford. Il, A Municipal Corporation, Fire Dept.
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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **12/15/2017**. 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

18IWCC0561

On the date of accident, **1/16/2014**, 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 $**104,000.00**; the average weekly wage was $**2,000.00**.

On the date of accident, Petitioner was **54** 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 **full salary paid during periods of temporary total disability** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $

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

ORDER

Respondent shall pay permanent partial disability benefits of $721.66 a week for 37.625 weeks, because the injury sustained caused the 17-1/2% loss of use of the right leg, pursuant to Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services of $360.00, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

1/30/18
Date

ICArbDec19(b)

FEB 5 - 2018

18IWCC0561

FINDINGS OF FACTS

On January 16, 2014, Petitioner was employed as a firefighter for the City of Rockford Fire Department. He had worked for the Fire Department since 1988 and had reached the position of Captain by the time he was injured on January 16, 2014. Petitioner testified that although he was a Captain, he was still expected to perform the heavy work of a firefighter. This included both emergency medical service and fire suppression. Petitioner testified that he had previous work-related injuries that occurred on November 25, 2007, May 1, 2009 and February 12, 2010. Those claims were previously arbitrated and decisions were rendered. The February 12, 2010 accident involved Petitioner falling off the roof of a house and sustaining severe injuries to multiple parts of his body. He had not filed any type of workers' compensation claim for his right knee prior to the January 16, 2014 accident.

Petitioner testified that he did have treatment to his right knee in 2006 with Dr. Robert Jarrett, an orthopedic surgeon. Petitioner stated that while this was a work-related injury, he did not file a claim with the Commission, nor did he receive any type of settlement. The treatment for that incident consisted of three visits with the physician and an MRI of the right knee performed on January 3, 2007. The MRI reportedly revealed mild chondromalacia of the patella. (PX 3, pp. 6-8) He was released from care in January of 2007.

Petitioner testified that he did not receive any treatment for his right knee from 2007 through the incident of January 16, 2014. Petitioner testified that on June 17, 2010, he saw Dr. Brian Cole at Midwest Orthopedics in relation to his left knee. Petitioner indicated that during the evaluation, Dr. Cole noted some mild pain and swelling in the right knee. Petitioner went on to have a medial unicondylar left knee arthroplasty in 2011, by Dr. Levine of Midwest Orthopedics. He was returned to work full duty. Petitioner stated that in 2013, his right knee was starting to hurt.

On January 16, 2014, Petitioner was working in fire suppression. He was performing full duty work at that time. Petitioner testified that on that day he was involved in a fire in a subdivision. There had been significant snowfall during the day. Due to the fact that an ambulance had gotten stuck in the snow, Petitioner went back to the truck to get a backboard to carry a victim. While carrying the backboard to the scene, Petitioner slipped on ice and twisted his right knee. Petitioner testified he felt pain in the right knee shortly after the incident occurred. After returning to the firehouse, he logged the incident on the fire department computer and notified his district chief. (PX 5, pp.16-19)

Petitioner testified that he did not seek immediate medical care stating he "tri[ed] to toughen it out" with the hope of returning to baseline. Over the next couple of weeks, he noted that the knee was swelling and becoming more painful while performing his duties. In the beginning of February, 2014, Petitioner requested medical care for his right knee. He was directed to obtain treatment with Dr. Borchardt at Ortho Illinois. Petitioner saw Dr. Borchardt on February 5, 2014. Dr. Borchardt recommended an MRI of the right knee, which was performed on February 14, 2014. The radiologist's interpretation was: "Small tear in the medial meniscus extends to the inferior articular surface. Myxoid degeneration in the menisci. Degenerative arthritis. Articular cartilage defects. Small joint effusion." (PX 3, pp. 9-12) Petitioner returned to Dr. Borchardt on February 19, 2014 to review the results of the MRI. At that time, Petitioner was complaining of pain at a 4/10 level while at rest and a 7/10 level with activity. The patellar grind test and McMurray's test were both positive. Dr. Borchardt reviewed the MRI results noting Petitioner had a small meniscus tear. At that time Petitioner noted that his pain had improved and denied any mechanical symptoms. Dr. Borchardt noted Petitioner wished to wait before considering an invasive measure such as steroid injections, Synvisc injections

or arthroscopic surgery. A home exercise program was recommended and he was returned to regular work. (PX 3, pp.13-14)

Petitioner testified that on July 3, 2014, he was testing equipment. He was loading hoses on the back of the "rig." As part of the process, he was required to repeatedly go up and down on the back bumper. Petitioner stated he noticed increased right knee pain and swelling. Petitioner prepared the appropriate accident report records by using the fire department computer system. (PX 5, p. 22)

Petitioner did not seek additional treatment until July 16, 2014 when he returned to Dr. Borchardt. At that time he gave a history of increased pain in the right knee while repeatedly climbing on and off a fire truck while hose testing. Dr. Borchardt examined Petitioner's right knee. The range of motion was from 0 degrees of extension to 120 degrees of flexion. There was medial joint line tenderness. Dr. Borchardt recommended instituting physical therapy and prescribed an unloader brace. (PX 3, pp.68-69)

Petitioner returned to Dr. Borchardt on July 31, 2014. On that visit Petitioner reported his pain level to be 6/10 at rest and 8/10 with activity. It was noted to be a dull and throbbing pain. He also had symptoms of popping, locking-up, and giving out. Dr. Borchardt noted that Petitioner had not started physical therapy as they were awaiting "Work Comp" approval. The physical exam was similar to that of July 16, 2014. Dr. Borchardt renewed his physical therapy and unloader brace prescription order. (PX 3, pp.65-66) Ultimately, physical therapy was initiated on August 4, 2014 and continued through October 27, 2014. At that time, Petitioner was still performing the full duties of a firefighter. He eventually obtained the unloader brace in early September 2014. (PX 3, p. 37) On October10, 2014, Dr. Borchardt noted Petitioner's main complaint consisted of pain. Physical therapy appeared beneficial. The physical exam was similar to the previous examination. Dr. Borchardt believed Petitioner was a good candidate for Synvisc injections at the completion of physical therapy. (PX 3, pp.31-32) By November 4, 2014, Petitioner reported his pain as 5/10 at rest and 8/10 with activity. He told Dr. Borchardt that he felt about the same. Dr. Borchardt told Petitioner to return in two months, or earlier if the Synvisc injections were approved. (PX 3, pp.19-20)

Petitioner testified to a third incident that occurred on November 30, 2014. Petitioner testified that he responded to a fully-involved house fire. At that point in time, he was in full fire gear that weighed over 100 pounds. While in the process of fighting the fire, he descended the basement steps with a hose in his right hand. He noted the steps to be old and wet. Petitioner stated that as he was descending the stairs, he slipped and twisted his right knee. Petitioner testified that upon return to the station he completed an accident report. He noted twisting his right knee and lower back while in the basement of the residence. Petitioner complained of medial right knee pain and lower lumbar back pain at the time. (PX 5, p. 38) Once again, he did not seek immediate medical treatment and continued to work. The company records indicate that he went home at 4:00 p.m. on December 15, 2014 due to back and knee pain. (PX 5, p. 15)

Petitioner returned to Dr. Borchardt on December 17, 2014. Petitioner reported that he experienced right knee medial side and low back pain while working a fire on November 30, 2014. Petitioner reported pain level was 5/10 at rest and 8/10 with activity. His right knee symptoms were pain, instability, weakness and giving-way. His low back symptoms were pain and numbness in the lower back. This examination was similar to those performed by Dr. Borchardt in the past. Dr. Borchardt performed a Synvisc injection into the right knee joint. Petitioner was instructed to return in two months or earlier if necessary. (PX 3, pp. 16-17) The employer records indicate that he returned to work on December 27, 2014. (PX 5, p. 14)

Petitioner testified that he then decided to return to see Dr. Brian Cole at Midwest Orthopedics at Rush. The employer records indicate that he began seeking approval of the visit through PMA in February 2015. Approval was given in March 2015, and an appointment was made with Dr. Cole on April 2, 2015. At that visit Dr. Cole noted a one-year history of medial-sided right knee pain after an event at work in January 2014. He

further noted that after sitting for 20 minutes, Petitioner would have to get up and walk several steps to relieve the stiffness and discomfort. He had pain with walking greater than one block. He had been off work for approximately one month at that time. Dr. Cole noted trace effusion in the knee along with medial joint line tenderness to palpation. Dr. Cole assessed right knee medial compartment osteoarthritis. Dr. Cole indicated that much of his discomfort would most likely be relieved by consideration of a unicompartment. He felt that a simple arthroscopy and utilization of cortisone would only be a 50/50 shot on providing much benefit. He left it up to Petitioner as to whether or not he could perform his work as a firefighter. Finally, he suggested that Petitioner return to Dr. Levine. (PX 2, p. pp. 6-8)

Petitioner ultimately received approval to see Dr. Levine. Petitioner saw Dr. Levine on June 1, 2015. After examining Petitioner, Dr. Levine indicated that he was a candidate for a uni-compartmental knee arthroplasty. While the office note contains the phrase "not a reasonable candidate" this is contrary to the following:

> "...He wants to get it set up sometime in August. He is going to have to contact the workers' compensation department. We will send our notes in, but I think it is reasonable to go ahead with that. In the meantime, he is going to return back to work full-duty and put up with this for a couple more months before he moves over to an elective unicompartmental knee arthroplasty." (PX 2, p. 5)

On June 4, 2015, Petitioner returned to full-duty work. (PX 5, p. 3) As part of the return to work, Petitioner was evaluated by Dr. Borchardt for a fitness for duty on August 3, 2015 . After the evaluation, Dr. Borchardt prepared a narrative report directed to the City. The evaluation noted medial joint line tenderness with a positive McMurray sign. There was also mild patellar grinding. Dr. Borchardt opined that Petitioner's buckling sensation was not due to instability, but instead from acute discomfort in the knee while in certain positions. He suggested that as long as Petitioner wore his unloader brace, he should not have that discomfort. (PX 3, p. 71)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Kevin Walsh on September 14, 2015. Dr. Walsh was asked to review medical records pertaining to his prior claims as well as the January 16, 2014 incident. It appears that a more comprehensive evaluation of the left knee was performed and Dr. Walsh only took a history of the January 2014 incident. He does not refer to the July 2014 or November 2014 incidents in his report dated September 20, 2015. Dr. Walsh wrote:

> "He reports a new injury in January 2014, at which time he believes he injured his right knee while walking through the snow. He reports the fire truck could not get to the home. He had to walk 1000 feet. He believes he twisted his knee while walking and falling in the snow...He has seen Dr. Brett Levine who has advised him to consider a knee replacement. More likely than not,... it is not at all likely the episode described by the patient requires a partial knee replacement. Although the patient may have had pain walking through the snow, the unicompartmental knee replacement is for osteoarthritis. The patient did not develop osteoarthritis as a result of a single activity on one particular day, nor is he likely to have suffered any permanent aggravation or acceleration of his underlying arthritis." (RX 1)

Dr. Walsh opined that there was no causal connection between the recommendation of a unicompartmental knee replacement and the injury described. He felt Petitioner could proceed with the recommended surgery, but same would be unrealetd to the specific work injury described. (RX 1)

Petitioner returned to Dr. Borchardt on November 10, 2015. On this visit Petitioner reported pain level was 6/10 at rest and 9/10 with activity. He once again complained of catching and locking, weakness,

instability and swelling. Dr. Borchardt noted moderate effusion. The medial joint line was still tender. His range of motion was 0 degrees of extension through 90 degrees of flexion. A decreased Lachman. A steroid injection was performed and Petitioner was informed to return as needed. (PX 3, pp.73-74)

18IWCC0561

At his request, Petitioner underwent a Section 12 examination with orthopedic surgeon Dr. Stephen Weiss on March 14, 2017. (PX 4) Petitioner had previously seen Dr. Weiss on April 18, 2014 in conjunction with the previously-tried cases. At the March 14, 2017 exam, Dr. Weiss evaluated both the right knee and the parts of the body he had examined in 2014. Dr. Weiss had the treatment records of Dr. Borchardt, Dr. Levine, Dr. Cole, and Dr. Walsh's exam. In addition to the records, he reviewed MRI imaging studies from February 14, 2014. His examination of the right knee revealed full range of motion from 0 to 130 degrees. He also noted medial joint line tenderness and a positive modified medial Apley. Dr. Weiss testified that he believed that the January 16, 2014 and July 3, 2014 incidents both permanently aggravated pre-existing arthritis. He was not sure if the November 2014 incident was a permanent aggravation or a temporary exacerbation. He further opined that when Petitioner became sufficiently symptomatic, and injections did not help, some form of replacement, either a unicondylar or total replacement could be considered. (PX 4, pp. 25-26) Dr. Weiss also indicated that Petitioner needed to limit the amount stair climbing he could do and avoid all ladder climbing. He also did not believe Petitioner should carry anything more than 40 pounds for a distance greater than 20 feet. Finally, he testified that in his opinion, the condition of ill being involving the right knee was permanent. (PX 4, pp. 27-28)

Petitioner testified that he continues to have significant pain in his right knee at the present time. He testified that he does not take NSAIDs or narcotics at the present time because of past negative reactions to those medications. He further testified that he has attempted to stay active since his retirement and has participated in Habitat for Humanity as well as a peer support program for public safety employees with substance abuse or psychological issues. He attempted to work at a home improvement store in the plumbing department, but left after three or four months due to increased pain caused by excessive standing. He does continue to attempt to perform physical workouts, but finds that he does not have the capacity to perform at his pre-injury level.

In regards to F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

There is no dispute that Petitioner suffered three separate events involving his right knee in 2014. While Petitioner did have some treatment to the right knee in late 2006 and early 2007, an MRI performed on January 3, 2007 did not reveal any pathology involving the meniscus or articular surfaces. He had no specific treatment to the right knee from January 16, 2007 until the January 16, 2014 accident. Shortly after that accident, an MRI revealed a meniscal tear and articular cartilage defects. From January 16, 2014 forward, Petitioner had ongoing and progressive pain in the right knee that required more intensive treatment as time went on. He initially treated with physical therapy. Later, he required more therapy and an unloader brace. Finally he required Synvisc and cortisone injections. During this time his subjective complaints worsened and his clinical exam deteriorated.

On June 1, 2015, Dr. Brett Levine of Midwest Orthopedics at Rush agreed that a unicondylar replacement procedure would be appropriate. Petitioner told the doctor that he wanted to forestall that procedure for at least a couple of months and continued to work. Dr. Stephen Weiss, Petitioner's examining doctor, agreed with that course of action. It appears that at some point in time, Petitioner will need to proceed with a partial or total replacement.

After reviewing all of the evidence and considering Petitioner's testimony, the Arbitrator finds that Petitioner has met his burden on the issue of casual relationship. Beginning with the January 16, 2014 injury, the condition of Petitioner's right knee has progressively deteriorated. An MRI done shortly after that injury

showed a torn meniscus within the knee. Clearly the January 16, 2014 accident initiated the deterioration of the right knee. The Arbitrator further finds that while the incidents on July 3, 2014 and November 30, 2014 could be considered separate accidents, they are more appropriately classified as symptomatic manifestations of the January 16, 2014 injury.

The Arbitrator gives more weight and adopts the opinion of Dr. Weiss over that of Dr. Walsh. The Arbitrator notes Dr. Weiss reviewed all of the treating medical as well as the actual imaging studies. He is familiar with the history of all three incidents and discussed them in detail with Petitioner. The basis of the opinions rendered both in his report and in his deposition testimony are well reasoned and well supported by the evidence.

The Arbitrator is not persuaded by the opinion of Dr. Walsh. In reviewing Dr. Walsh's report, it was not clear whether he had the actual medical records regarding the treatment rendered after the 2014 incidents. It is clear that he did not have the imaging studies to review. Finally, it appears that he limited his inquiry to the January 16, 2014 injury. There is no reference to the July 2014 or November 2014 incidents in his report. In addition he does not provide a specific medical basis for his opinions. Based on all of the above, the Arbitrator finds in favor of Petitioner on the issue of casual relationship.

In regards 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 the following:

Having found in Petitioner's favor in the issues of casual relationship, the Arbitrator awards unpaid medical of $360.00 to be paid pursuant to the fee schedule. The Arbitrator notes that Respondent's objection was based only on liability.

In regards to L.) What is the nature and extent of the injury, the Arbitrator finds the following:

In determining the level of permanent partial disability for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to the most current edition of the American Medical Associations "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records, (820 ILCS 305/8.1b(b).

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 level of impairment as reported by the physician must be explained in a written order.

With regard to §(i) of Section 8.1b(b), the Arbitrator notes that the record contains no impairment rating and therefore gives no weight to this factor.

With regard to §(ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Captain on the Rockford Fire Department at the time of the accident. Petitioner chose to retire at the end of 2015. Petitioner testified that he has attempted to work in a home improvement store, but discontinued his employment because of the continuous standing required by the job. The Arbitrator gives some weight to this factor.

With regard to §(iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 54 years of age at the time of the accident. Because Petitioner will live with his permanent disability for shorter period than a younger individual, the Arbitrator gives some weight to this factor.

With regard to § (iv) of Section 8.1b(b), Petitioner's future earning capacity, the Arbitrator notes that no evidence was presented to show the effect on Petitioner's future earning capacity. The Arbitrator therefore gives no weight to this factor.

With regard to § (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that when Petitioner last saw Dr. Borchardt on November 10, 2015, Petitioner had decreased range of motion and a moderate effusion. There was still tenderness to palpation of the medial joint line. Petitioner's testimony of ongoing complaints is consistent with the medical records. His need to use the unloader brace is consistent with the findings on x-ray and MRI. Dr. Levine indicated in 2015 that a unicondylar replacement of the right knee was appropriate. Petitioner testified that he had no plans to proceed with surgery and that he would "probably wait." The Arbitrator, therefore, gives greater weight to this factor.

Based upon the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17-1/2% loss of use of the right leg pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph A. Cascio,

Petitioner,

vs.

NO: 15WC 17720

City of Rockford, Rockford, IL,
A Municipal Corporation, Fire Department,

18IWCC0562

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 5, 2018 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.

18IWCC0562

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: SEP 18 2018
SJM/sj
o-8/30/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASCIO, JOSEPH
Employee/Petitioner

Case# **15WC017720**

15WC018472
15WC020501

18IWCC0562

CITY OF ROCKFORD ROCKFORD IL A MUNICIPAL CORPORATION FIRE DEPT
Employer/Respondent

On 2/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% 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:

0529 TUITE LAW
GREGORY TUITE
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

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

STATE OF ILLINOIS)SS.

COUNTY OF Winnebago)

18IWCC0562

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joseph A. Cascio
Employee/Petitioner

v.

Case # 15 WC 17720

Consolidated cases: 15 WC 18472; 15 WC 20501

City of Rockford, Rockford. Il, A Municipal Corporation, Fire Dept.
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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **12/15/2017**. 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 _____

18IWCC0562

FINDINGS

On the date of accident, **7/3/2014**, 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 **$104,000.00**; the average weekly wage was **$2,000.00**.

On the date of accident, Petitioner was **54** 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 **full salary paid during periods of temporary total disability** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $

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

ORDER

This case was consolidated and heard with cases 15 WC 18472 and 15 WC 18472. All issues have been disposed of in case 15 WC 18472.

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

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

Signature of Arbitrator

1/30/18
Date

ICArbDec19(b)

FEB 5 - 2018

19IWCC0562

FINDINGS OF FACTS

On January 16, 2014, Petitioner was employed as a firefighter for the City of Rockford Fire Department. He had worked for the Fire Department since 1988 and had reached the position of Captain by the time he was injured on January 16, 2014. Petitioner testified that although he was a Captain, he was still expected to perform the heavy work of a firefighter. This included both emergency medical service and fire suppression. Petitioner testified that he had previous work-related injuries that occurred on November 25, 2007, May 1, 2009 and February 12, 2010. Those claims were previously arbitrated and decisions were rendered. The February 12, 2010 accident involved Petitioner falling off the roof of a house and sustaining severe injuries to multiple parts of his body. He had not filed any type of workers' compensation claim for his right knee prior to the January 16, 2014 accident.

Petitioner testified that he did have treatment to his right knee in 2006 with Dr. Robert Jarrett, an orthopedic surgeon. Petitioner stated that while this was a work-related injury, he did not file a claim with the Commission, nor did he receive any type of settlement. The treatment for that incident consisted of three visits with the physician and an MRI of the right knee performed on January 3, 2007. The MRI reportedly revealed mild chondromalacia of the patella. (PX 3, pp. 6-8) He was released from care in January of 2007.

Petitioner testified that he did not receive any treatment for his right knee from 2007 through the incident of January 16, 2014. Petitioner testified that on June 17, 2010, he saw Dr. Brian Cole at Midwest Orthopedics in relation to his left knee. Petitioner indicated that during the evaluation, Dr. Cole noted some mild pain and swelling in the right knee. Petitioner went on to have a medial unicondylar left knee arthroplasty in 2011, by Dr. Levine of Midwest Orthopedics. He was returned to work full duty. Petitioner stated that in 2013, his right knee was starting to hurt.

On January 16, 2014, Petitioner was working in fire suppression. He was performing full duty work at that time. Petitioner testified that on that day he was involved in a fire in a subdivision. There had been significant snowfall during the day. Due to the fact that an ambulance had gotten stuck in the snow, Petitioner went back to the truck to get a backboard to carry a victim. While carrying the backboard to the scene, Petitioner slipped on ice and twisted his right knee. Petitioner testified he felt pain in the right knee shortly after the incident occurred.

Dr. Borchardt initially received treatment with Dr. Borchardt at Ortho Illinois on February 5, 2014. An MRI of the right knee was obtained and demonstrated a "Small tear in the medial meniscus extends to the inferior articular surface. Myxoid degeneration in the menisci. Degenerative arthritis. Articular cartilage defects. Small joint effusion." (PX 3, pp. 9-12) Petitioner returned to Dr. Borchardt on February 19, 2014. Dr. Borchardt reviewed the MRI results noting Petitioner had a small meniscus tear. At that time, Dr. Borchardt noted Petitioner wished to wait before considering an invasive measure such as steroid injections, Synvisc injections or arthroscopic surgery. A home exercise program was recommended and he was returned to regular work. (PX 3, pp.13-14)

Petitioner testified that on July 3, 2014, he was testing equipment. He was loading hoses on the back of the "rig." As part of the process, he was required to repeatedly go up and down on the back bumper. Petitioner stated he noticed increased right knee pain and swelling. Petitioner prepared the appropriate accident report records by using the fire department computer system. (PX 5, p. 22)

Petitioner did not seek additional treatment until July 16, 2014 when he returned to Dr. Borchardt. At that time he gave a history of increased pain in the right knee while repeatedly climbing on and off a fire truck while hose testing. Dr. Borchardt examined Petitioner's right knee. The range of motion was from 0 degrees of extension to 120 degrees of flexion. There was medial joint line tenderness. Dr. Borchardt recommended instituting physical therapy and prescribed an unloader brace. (PX 3, pp.68-69)

Petitioner returned to Dr. Borchardt on July 31, 2014. On that visit Petitioner reported his pain level to be 6/10 at rest and 8/10 with activity. It was noted to be a dull and throbbing pain. He also had symptoms of popping, locking-up, and giving out. Dr. Borchardt noted that Petitioner had not started physical therapy as they were awaiting "Work Comp" approval. The physical exam was similar to that of July 16, 2014. Dr. Borchardt renewed his physical therapy and unloader brace prescription order. (PX 3, pp.65-66) Ultimately, physical therapy was initiated on August 4, 2014 and continued through October 27, 2014. At that time, Petitioner was still performing the full duties of a firefighter. He eventually obtained the unloader brace in early September 2014. (PX 3, p. 37) On October10, 2014, Dr. Borchardt noted Petitioner's main complaint consisted of pain. Physical therapy appeared beneficial. The physical exam was similar to the previous examination. Dr. Borchardt believed Petitioner was a good candidate for Synvisc injections at the completion of physical therapy. (PX 3, pp.31-32) By November 4, 2014, Petitioner reported his pain as 5/10 at rest and 8/10 with activity. He told Dr. Borchardt that he felt about the same. Dr. Borchardt told Petitioner to return in two months, or earlier if the Synvisc injections were approved. (PX 3, pp.19-20)

Petitioner testified to a third incident that occurred on November 30, 2014. Petitioner testified that he responded to a fully-involved house fire. At that point in time, he was in full fire gear that weighed over 100 pounds. While in the process of fighting the fire, he descended the basement steps with a hose in his right hand. He noted the steps to be old and wet. Petitioner stated that as he was descending the stairs, he slipped and twisted his right knee. Petitioner testified that upon return to the station he completed an accident report. He noted twisting his right knee and lower back while in the basement of the residence. Petitioner complained of medial right knee pain and lower lumbar back pain at the time. (PX 5, p. 38) Once again, he did not seek immediate medical treatment and continued to work. The company records indicate that he went home at 4:00 p.m. on December 15, 2014 due to back and knee pain. (PX 5, p. 15)

Petitioner returned to Dr. Borchardt on December 17, 2014. Petitioner reported that he experienced right knee medial side and low back pain while working a fire on November 30, 2014. Petitioner reported pain level was 5/10 at rest and 8/10 with activity. His right knee symptoms were pain, instability, weakness and giving-way. His low back symptoms were pain and numbness in the lower back. This examination was similar to those performed by Dr. Borchardt in the past. Dr. Borchardt performed a Synvisc injection into the right knee joint. Petitioner was instructed to return in two months or earlier if necessary. (PX 3, pp. 16-17) The employer records indicate that he returned to work on December 27, 2014. (PX 5, p. 14)

Petitioner testified that he then decided to return to see Dr. Brian Cole at Midwest Orthopedics at Rush. The employer records indicate that he began seeking approval of the visit through PMA in February 2015. Approval was given in March 2015, and an appointment was made with Dr. Cole on April 2, 2015. At that visit Dr. Cole noted a one-year history of medial-sided right knee pain after an event at work in January 2014. He further noted that after sitting for 20 minutes, Petitioner would have to get up and walk several steps to relieve the stiffness and discomfort. He had pain with walking greater than one block. He had been off work for approximately one month at that time. Dr. Cole noted trace effusion in the knee along with medial joint line tenderness to palpation. Dr. Cole assessed right knee medial compartment osteoarthritis. Dr. Cole indicated that much of his discomfort would most likely be relieved by consideration of a unicompartment. He felt that a simple arthroscopy and utilization of cortisone would only be a 50/50 shot on providing much benefit. He left it up to Petitioner as to whether or not he could perform his work as a firefighter. Finally, he suggested that Petitioner return to Dr. Levine. (PX 2, p. pp. 6-8)

Petitioner ultimately received approval to see Dr. Levine. Petitioner saw Dr. Levine on June 1, 2015. After examining Petitioner, Dr. Levine indicated that he was a candidate for a uni-compartmental knee arthroplasty. While the office note contains the phrase "not a reasonable candidate" this is contrary to the following:

> "...He wants to get it set up sometime in August. He is going to have to contact the workers' compensation department. We will send our notes in, but I think it is reasonable to go ahead with that. In the meantime, he is going to return back to work full-duty and put up with this for a couple more months before he moves over to an elective unicompartmental knee arthroplasty." (PX 2, p. 5)

On June 4, 2015, Petitioner returned to full-duty work. (PX 5, p. 3) As part of the return to work, Petitioner was evaluated by Dr. Borchardt for a fitness for duty on August 3, 2015 . After the evaluation, Dr. Borchardt prepared a narrative report directed to the City. The evaluation noted medial joint line tenderness with a positive McMurray sign. There was also mild patellar grinding. Dr. Borchardt opined that Petitioner's buckling sensation was not due to instability, but instead from acute discomfort in the knee while in certain positions. He suggested that as long as Petitioner wore his unloader brace, he should not have that discomfort. (PX 3, p. 71)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Kevin Walsh on September 14, 2015. Dr. Walsh was asked to review medical records pertaining to his prior claims as well as the January 16, 2014 incident. It appears that a more comprehensive evaluation of the left knee was performed and Dr. Walsh only took a history of the January 2014 incident. He does not refer to the July 2014 or November 2014 incidents in his report dated September 20, 2015. Dr. Walsh wrote:

> "He reports a new injury in January 2014, at which time he believes he injured his right knee while walking through the snow. He reports the fire truck could not get to the home. He had to walk 1000 feet. He believes he twisted his knee while walking and falling in the snow...He has seen Dr. Brett Levine who has advised him to consider a knee replacement. More likely than not,... it is not at all likely the episode described by the patient requires a partial knee replacement. Although the patient may have had pain walking through the snow, the unicompartmental knee replacement is for osteoarthritis. The patient did not develop osteoarthritis as a result of a single activity on one particular day, nor is he likely to have suffered any permanent aggravation or acceleration of his underlying arthritis." (RX 1)

Dr. Walsh opined that there was no causal connection between the recommendation of a unicompartmental knee replacement and the injury described. He felt Petitioner could proceed with the recommended surgery, but same would be unrealetd to the specific work injury described. (RX 1)

Petitioner returned to Dr. Borchardt on November 10, 2015. On this visit Petitioner reported pain level was 6/10 at rest and 9/10 with activity. He once again complained of catching and locking, weakness, instability and swelling. Dr. Borchardt noted moderate effusion. The medial joint line was still tender. His range of motion was 0 degrees of extension through 90 degrees of flexion, a decrease in flexion. A steroid injection was performed and Petitioner was informed to return as needed. (PX 3, pp.73-74)

At his request, Petitioner underwent a Section 12 examination with orthopedic surgeon Dr. Stephen Weiss on March 14, 2017. (PX 4) Petitioner had previously seen Dr. Weiss on April 18, 2014 in conjunction with the previously-tried cases. At the March 14, 2017 exam, Dr. Weiss evaluated both the right knee and the parts of the body he had examined in 2014. Dr. Weiss had the treatment records of Dr. Borchardt, Dr. Levine,

Dr. Cole, and Dr. Walsh's exam. In addition to the records, he reviewed MRI imaging studies from February 14, 2014. His examination of the right knee revealed full range of motion from 0 to 130 degrees. He also noted medial joint line tenderness and a positive modified medial Apley. Dr. Weiss testified that he believed that the January 16, 2014 and July 3, 2014 incidents both permanently aggravated pre-existing arthritis. He was not sure if the November 2014 incident was a permanent aggravation or a temporary exacerbation. He further opined that when Petitioner became sufficiently symptomatic, and injections did not help, some form of replacement, either a unicondylar or total replacement could be considered. (PX 4, pp. 25-26) Dr. Weiss also indicated that Petitioner needed to limit the amount stair climbing he could do and avoid all ladder climbing. He also did not believe Petitioner should carry anything more than 40 pounds for a distance greater than 20 feet. Finally, he testified that in his opinion, the condition of ill being involving the right knee was permanent. (PX 4, pp. 27-28)

Petitioner testified that he continues to have significant pain in his right knee at the present time. He testified that he does not take NSAIDs or narcotics at the present time because of past negative reactions to those medications. He further testified that he has attempted to stay active since his retirement and has participated in Habitat for Humanity as well as a peer support program for public safety employees with substance abuse or psychological issues. He attempted to work at a home improvement store in the plumbing department, but left after three or four months due to increased pain caused by excessive standing. He does continue to attempt to perform physical workouts, but finds that he does not have the capacity to perform at his pre-injury level.

In regards 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:

Petitioner's unrebutted testimony was that on July 3, 2014, he was testing equipment. He was loading hoses on the back of the "rig." As part of the process, he was required to repeatedly go up and down on the back bumper. Petitioner stated he noticed increased right knee pain and swelling. That same day Petitioner prepared an accident report consistent with his testimony. Furthermore, when Petitioner saw Dr. Borchardt on July 16, 2014, he gave a history of increased pain in the right knee while repeatedly climbing on and off a fire truck while hose testing.

Relying on Petitioner's credible and rebutted testimony, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment on July 3, 2014.

See companion case 15 WC 18472 for all remaining issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph A. Cascio,

Petitioner,

vs.

NO: 15WC020501

City of Rockford, Rockford, IL,
A Municipal Corporation, Fire Department,

18IWCC0563

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 5, 2018 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court. 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.

SEP 18 2018

DATED:
SJM/sj
o-8/30/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASCIO, JOSEPH A
Employee/Petitioner

Case# **15WC020501**

15WC017720
15WC018472

CITY OF ROCKFORD ROCKFORD IL A MUNICIPAL CORPORATION FIRE DEPT
Employer/Respondent

18IWCC0563

On 2/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% 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:

0529 TUITE LAW
GREGORY TUITE
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

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

STATE OF ILLINOIS 18IWCC0563

)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

Joseph A. Cascio
Employee/Petitioner

v.

Case # **15** WC **20501**

Consolidated cases: 15 WC 17720; 15 WC 18472

City of Rockford, Rockford. Il, A Municipal Corporation, Fire Dept.
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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **12/15/2017**. 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 the date of accident, **11/30/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$104,000.00**; the average weekly wage was **$2,000.00**.

On the date of accident, Petitioner was **55** years of age ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **full salary paid during periods of temporary total disability** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $

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

ORDER

This case was consolidated and heard with cases 15 WC 17720 and 15 WC 18472. All issues have been disposed of in case 15 WC 18472.

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

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

Signature of Arbitrator

1/30/18
Date

ICArbDec19(b)

FEB 5 - 2018

Attachment to Arbitrator Decision
(15 WC 20501;15 WC 18472; 15 WC 17720)

FINDINGS OF FACTS

On January 16, 2014, Petitioner was employed as a firefighter for the City of Rockford Fire Department. He had worked for the Fire Department since 1988 and had reached the position of Captain by the time he was injured on January 16, 2014. Petitioner testified that although he was a Captain, he was still expected to perform the heavy work of a firefighter. This included both emergency medical service and fire suppression. Petitioner testified that he had previous work-related injuries that occurred on November 25, 2007, May 1, 2009 and February 12, 2010. Those claims were previously arbitrated and decisions were rendered. The February 12, 2010 accident involved Petitioner falling off the roof of a house and sustaining severe injuries to multiple parts of his body. He had not filed any type of workers' compensation claim for his right knee prior to the January 16, 2014 accident.

Petitioner testified that he did have treatment to his right knee in 2006 with Dr. Robert Jarrett, an orthopedic surgeon. Petitioner stated that while this was a work-related injury, he did not file a claim with the Commission, nor did he receive any type of settlement. The treatment for that incident consisted of three visits with the physician and an MRI of the right knee performed on January 3, 2007. The MRI reportedly revealed mild chondromalacia of the patella. (PX 3, pp. 6-8) He was released from care in January of 2007.

Petitioner testified that he did not receive any treatment for his right knee from 2007 through the incident of January 16, 2014. Petitioner testified that on June 17, 2010, he saw Dr. Brian Cole at Midwest Orthopedics in relation to his left knee. Petitioner indicated that during the evaluation, Dr. Cole noted some mild pain and swelling in the right knee. Petitioner went on to have a medial unicondylar left knee arthroplasty in 2011, by Dr. Levine of Midwest Orthopedics. He was returned to work full duty. Petitioner stated that in 2013, his right knee was starting to hurt.

On January 16, 2014, Petitioner was working in fire suppression. He was performing full duty work at that time. Petitioner testified that on that day he was involved in a fire in a subdivision. There had been significant snowfall during the day. Due to the fact that an ambulance had gotten stuck in the snow, Petitioner went back to the truck to get a backboard to carry a victim. While carrying the backboard to the scene, Petitioner slipped on ice and twisted his right knee. Petitioner testified he felt pain in the right knee shortly after the incident occurred.

Dr. Borchardt initially received treatment with Dr. Borchardt at Ortho Illinois on February 5, 2014. An MRI of the right knee was obtained and demonstrated a "Small tear in the medial meniscus extends to the inferior articular surface. Myxoid degeneration in the menisci. Degenerative arthritis. Articular cartilage defects. Small joint effusion." (PX 3, pp. 9-12) Petitioner returned to Dr. Borchardt on February 19, 2014. Dr. Borchardt reviewed the MRI results noting Petitioner had a small meniscus tear. At that time, Dr. Borchardt noted Petitioner wished to wait before considering an invasive measure such as steroid injections, Synvisc injections or arthroscopic surgery. A home exercise program was recommended and he was returned to regular work. (PX 3, pp.13-14)

Petitioner testified that on July 3, 2014, he was testing equipment. He was loading hoses on the back of the "rig." As part of the process, he was required to repeatedly go up and down on the back bumper. Petitioner stated he noticed increased right knee pain and swelling. Petitioner prepared the appropriate accident report records by using the fire department computer system. (PX 5, p. 22)

Petitioner did not seek additional treatment until July 16, 2014 when he returned to Dr. Borchardt. At that time he gave a history of increased pain in the right knee while repeatedly climbing on and off a fire truck while hose testing. Dr. Borchardt examined Petitioner's right knee. The range of motion was from 0 degrees of extension to 120 degrees of flexion. There was medial joint line tenderness. Dr. Borchardt recommended instituting physical therapy and prescribed an unloader brace. (PX 3, pp.68-69)

Petitioner returned to Dr. Borchardt on July 31, 2014. On that visit Petitioner reported his pain level to be 6/10 at rest and 8/10 with activity. It was noted to be a dull and throbbing pain. He also had symptoms of popping, locking-up, and giving out. Dr. Borchardt noted that Petitioner had not started physical therapy as they were awaiting "Work Comp" approval. The physical exam was similar to that of July 16, 2014. Dr. Borchardt renewed his physical therapy and unloader brace prescription order. (PX 3, pp.65-66) Ultimately, physical therapy was initiated on August 4, 2014 and continued through October 27, 2014. At that time, Petitioner was still performing the full duties of a firefighter. He eventually obtained the unloader brace in early September 2014. (PX 3, p. 37) On October10, 2014, Dr. Borchardt noted Petitioner's main complaint consisted of pain. Physical therapy appeared beneficial. The physical exam was similar to the previous examination. Dr. Borchardt believed Petitioner was a good candidate for Synvisc injections at the completion of physical therapy. (PX 3, pp.31-32) By November 4, 2014, Petitioner reported his pain as 5/10 at rest and 8/10 with activity. He told Dr. Borchardt that he felt about the same. Dr. Borchardt told Petitioner to return in two months, or earlier if the Synvisc injections were approved. (PX 3, pp.19-20)

Petitioner testified to a third incident that occurred on November 30, 2014. Petitioner testified that he responded to a fully-involved house fire. At that point in time, he was in full fire gear that weighed over 100 pounds. While in the process of fighting the fire, he descended the basement steps with a hose in his right hand. He noted the steps to be old and wet. Petitioner stated that as he was descending the stairs, he slipped and twisted his right knee. Petitioner testified that upon return to the station he completed an accident report. He noted twisting his right knee and lower back while in the basement of the residence. Petitioner complained of medial right knee pain and lower lumbar back pain at the time. (PX 5, p. 38) Once again, he did not seek immediate medical treatment and continued to work. The company records indicate that he went home at 4:00 p.m. on December 15, 2014 due to back and knee pain. (PX 5, p. 15)

Petitioner returned to Dr. Borchardt on December 17, 2014. Petitioner reported that he experienced right knee medial side and low back pain while working a fire on November 30, 2014. Petitioner reported pain level was 5/10 at rest and 8/10 with activity. His right knee symptoms were pain, instability, weakness and giving-way. His low back symptoms were pain and numbness in the lower back. This examination was similar to those performed by Dr. Borchardt in the past. Dr. Borchardt performed a Synvisc injection into the right knee joint. Petitioner was instructed to return in two months or earlier if necessary. (PX 3, pp. 16-17) The employer records indicate that he returned to work on December 27, 2014. (PX 5, p. 14)

Petitioner testified that he then decided to return to see Dr. Brian Cole at Midwest Orthopedics at Rush. The employer records indicate that he began seeking approval of the visit through PMA in February 2015. Approval was given in March 2015, and an appointment was made with Dr. Cole on April 2, 2015. At that visit Dr. Cole noted a one-year history of medial-sided right knee pain after an event at work in January 2014. He further noted that after sitting for 20 minutes, Petitioner would have to get up and walk several steps to relieve the stiffness and discomfort. He had pain with walking greater than one block. He had been off work for approximately one month at that time. Dr. Cole noted trace effusion in the knee along with medial joint line tenderness to palpation. Dr. Cole assessed right knee medial compartment osteoarthritis. Dr. Cole indicated that much of his discomfort would most likely be relieved by consideration of a unicompartment. He felt that a simple arthroscopy and utilization of cortisone would only be a 50/50 shot on providing much benefit. He left it up to Petitioner as to whether or not he could perform his work as a firefighter. Finally, he suggested that Petitioner return to Dr. Levine. (PX 2, p. pp. 6-8)

Petitioner ultimately received approval to see Dr. Levine. Petitioner saw Dr. Levine on June 1, 2015. After examining Petitioner, Dr. Levine indicated that he was a candidate for a uni-compartmental knee arthroplasty. While the office note contains the phrase "not a reasonable candidate" this is contrary to the following:

> "...He wants to get it set up sometime in August. He is going to have to contact the workers' compensation department. We will send our notes in, but I think it is reasonable to go ahead with that. In the meantime, he is going to return back to work full-duty and put up with this for a couple more months before he moves over to an elective unicompartmental knee arthroplasty." (PX 2, p. 5)

On June 4, 2015, Petitioner returned to full-duty work. (PX 5, p. 3) As part of the return to work, Petitioner was evaluated by Dr. Borchardt for a fitness for duty on August 3, 2015 . After the evaluation, Dr. Borchardt prepared a narrative report directed to the City. The evaluation noted medial joint line tenderness with a positive McMurray sign. There was also mild patellar grinding. Dr. Borchardt opined that Petitioner's buckling sensation was not due to instability, but instead from acute discomfort in the knee while in certain positions. He suggested that as long as Petitioner wore his unloader brace, he should not have that discomfort. (PX 3, p. 71)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Kevin Walsh on September 14, 2015. Dr. Walsh was asked to review medical records pertaining to his prior claims as well as the January 16, 2014 incident. It appears that a more comprehensive evaluation of the left knee was performed and Dr. Walsh only took a history of the January 2014 incident. He does not refer to the July 2014 or November 2014 incidents in his report dated September 20, 2015. Dr. Walsh wrote:

> "He reports a new injury in January 2014, at which time he believes he injured his right knee while walking through the snow. He reports the fire truck could not get to the home. He had to walk 1000 feet. He believes he twisted his knee while walking and falling in the snow...He has seen Dr. Brett Levine who has advised him to consider a knee replacement. More likely than not,... it is not at all likely the episode described by the patient requires a partial knee replacement. Although the patient may have had pain walking through the snow, the unicompartmental knee replacement is for osteoarthritis. The patient did not develop osteoarthritis as a result of a single activity on one particular day, nor is he likely to have suffered any permanent aggravation or acceleration of his underlying arthritis." (RX 1)

Dr. Walsh opined that there was no causal connection between the recommendation of a unicompartmental knee replacement and the injury described. He felt Petitioner could proceed with the recommended surgery, but same would be unrealetd to the specific work injury described. (RX 1)

Petitioner returned to Dr. Borchardt on November 10, 2015. On this visit Petitioner reported pain level was 6/10 at rest and 9/10 with activity. He once again complained of catching and locking, weakness, instability and swelling. Dr. Borchardt noted moderate effusion. The medial joint line was still tender. His range of motion was 0 degrees of extension through 90 degrees of flexion, a decrease in flexion. A steroid injection was performed and Petitioner was informed to return as needed. (PX 3, pp.73-74)

At his request, Petitioner underwent a Section 12 examination with orthopedic surgeon Dr. Stephen Weiss on March 14, 2017. (PX 4) Petitioner had previously seen Dr. Weiss on April 18, 2014 in conjunction with the previously-tried cases. At the March 14, 2017 exam, Dr. Weiss evaluated both the right knee and the parts of the body he had examined in 2014. Dr. Weiss had the treatment records of Dr. Borchardt, Dr. Levine,

Dr. Cole, and Dr. Walsh's exam. In addition to the records, he reviewed MRI imaging studies from February 14, 2014. His examination of the right knee revealed full range of motion from 0 to 130 degrees. He also noted medial joint line tenderness and a positive modified medial Apley. Dr. Weiss testified that he believed that the January 16, 2014 and July 3, 2014 incidents both permanently aggravated pre-existing arthritis. He was not sure if the November 2014 incident was a permanent aggravation or a temporary exacerbation. He further opined that when Petitioner became sufficiently symptomatic, and injections did not help, some form of replacement, either a unicondylar or total replacement could be considered. (PX 4, pp. 25-26) Dr. Weiss also indicated that Petitioner needed to limit the amount stair climbing he could do and avoid all ladder climbing. He also did not believe Petitioner should carry anything more than 40 pounds for a distance greater than 20 feet. Finally, he testified that in his opinion, the condition of ill being involving the right knee was permanent. (PX 4, pp. 27-28)

Petitioner testified that he continues to have significant pain in his right knee at the present time. He testified that he does not take NSAIDs or narcotics at the present time because of past negative reactions to those medications. He further testified that he has attempted to stay active since his retirement and has participated in Habitat for Humanity as well as a peer support program for public safety employees with substance abuse or psychological issues. He attempted to work at a home improvement store in the plumbing department, but left after three or four months due to increased pain caused by excessive standing. He does continue to attempt to perform physical workouts, but finds that he does not have the capacity to perform at his pre-injury level.

In regards 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:

Petitioner's unrebutted testimony was that on November 30, 2014, he responded to a fully-involved house fire. Petitioner was in full fire gear that weighed over 100 pounds. While in the process of fighting the fire, he descended basement steps with a hose in his right hand. The steps were old and wet. As he was descending the stairs, he slipped and twisted his right knee. Records submitted show he completed an accident report. He noted twisting his right knee and lower back while in the basement of the residence. Petitioner complained of medial right knee pain and lower lumbar back pain at the time. Petitioner returned to Dr. Borchardt on December 17, 2014 when he reported that he experienced right knee medial side and low back pain while working a fire on November 30, 2014.

Relying on Petitioner's credible and rebutted testimony, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment on November 30, 2014.

See companion case 15 WC 18472 for all remaining issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juaria Holly

Petitioner,

vs. NO: 16WC00093

Chicago Youth Centers,

Respondent. 18IWCC0564

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2017 is hereby affirmed and adopted.

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

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

DATED: SEP 18 2018
SJM/sj
o-8/30/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOLLY, JUARIA
Employee/Petitioner

Case# **16WC000093**

CHICAGO YOUTH CENTERS
Employer/Respondent

18IWCC0564

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0696 RITTENBERG & BUFFEN LTD
STEVEN R SAKS
309 W WASHINGTON ST SUITE 900
CHICAGO, IL 60606

0560 WIEDNER & McAULIFFE LTD
LYNDSAY M COOK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0564

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

Juaria Holly
Employee/Petitioner

v.

Chicago Youth Centers
Employer/Respondent

Case # **16 WC 00093**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 19, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/4/15**, Respondent ***WAS*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**N/A**; the average weekly wage was **$350.00**.

On the date of accident, Petitioner was ***53*** 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 $**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

No medical bills, TTD benefits or permanency shall be awarded to Petitioner as she failed to establish an accident arising out of her employment with Respondent.

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

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

Signature of Arbitrator

Date 08-29-17

AUG 29 2017

18IWCC0564

Findings of Fact

On August 4, 2015, Juaria Holly ("Petitioner") was employed by the Chicago Youth Centers ("Respondent) as a paraprofessional. Her job duties involved providing support to classroom teachers with preschool children. Petitioner testified that she was assigned to a classroom located on the main level of the Chicago Youth Center. During the morning of August 4, 2015, petitioner walked downstairs to the lower level of the Chicago Youth Center in order to use the restroom.

After using the restroom and before proceeding back up the stairs, petitioner testified that she came into contact with Ms. Tanya Staggers, Director of the Chicago Youth Centers. Petitioner asserted that she was traveling up the stairwell on the right side and that Ms. Staggers was walking up the stairs directly behind her on the same side. Petitioner testified that she lost her balance while walking up the stairs, causing her to fall directly backward. Petitioner did not attribute her fall to any liquid, debris or defect in the stairs. She stated that she fell while turning around to address Ms. Staggers during conversation.

Ms. Staggers testified that she is employed in a supervisory position at the Chicago Youth Centers. She testified that she did, in fact, come into contact with petitioner in the lower level of Chicago Youth Center during the morning of August 4, 2015. Ms. Staggers further testified that the two women walked up the stairs side-by-side at the same pace, with Ms. Staggers traveling on left side and petitioner on the right side. As the two women proceeded up the stairs side-by-side, Ms. Staggers testified that petitioner suddenly tripped and fell forward onto the stairs in front of her. This testimony directly contradicted petitioner's testimony wherein she stated that she tripped and fell backward down the stairs.

On August 5, 2015, petitioner presented to Cook County Hospital with complaints of left foot pain after a fall on August 4, 2015. She denied any other injuries. The assessment was closed fracture of the left fifth toe. Petitioner was advised to follow up with podiatry. There was no indication that she was authorized off of work.

Petitioner was evaluated by Dr. Shah, a podiatrist, on August 7, 2015. She reported an injury to her left foot secondary to a fall while going up stairs on August 4, 2015. X-rays of the left foot confirmed a fracture through the distal diaphysis of the fifth metatarsal. Dr. Shah did not authorize petitioner off of work, but simply instructed her to return for a recheck in two weeks.

Dr. Shah reevaluated petitioner on August 21, 2015. Petitioner reported that she did not require use of crutches and had been weightbearing over the previous few days. Dr. Shah's assessment was status post fifth metatarsal fracture in the left foot. The medical records contain no indication that petitioner was authorized off of work in conjunction with her injuries.

Petitioner attended a follow up appointment with Dr. Pulla, Dr. Shah's colleague, on September 8, 2015. She reported a diminished pain level of 2/10 in the left foot. The assessment was left foot fifth metatarsal, healing. Petitioner was transitioned to a CAM boot. Dr. Pulla did not provide petitioner with an off-work authorization.

Petitioner was reevaluated by podiatry on September 22, 2015 and October 6, 2015. The assessment was unchanged and petitioner continued to utilize a CAM boot on the left foot. She was not advised to remain off of work.

On October 20, 2015, petitioner was reevaluated by Dr. Pulla where she reported decreased edema and decreased pain in the left foot. During a follow up appointment of November 10, 2015, petitioner reported that she was able to weight bear fully while using a CAM walker. Petitioner was not authorized off of work.

By December 15, 2015, the medical records reflect that petitioner had transitioned into regular shoes. Petitioner was reevaluated by podiatry on January 12, 2016. She continued to tolerate normal shoes and did not rely on orthotics. Petitioner was not authorized off of work.

Petitioner was reevaluated by podiatry on April 12, 2016. She denied having any ongoing pain in the left foot while wearing normal athletic shoes. X-rays showed healing of the left foot fracture line. During a follow-up appointment on May 20, 2016, Dr. Pulla advised petitioner to continue normal activities. She was not authorized off of work.

Petitioner was last evaluated by podiatry on July 15, 2016. She reported a pain level of zero to one out of ten in the left foot and continued to tolerate normal shoes. Physical examination showed no pain or edema in the left foot. Petitioner was discharged from medical care.

At trial, petitioner testified that she remained off of work from August 5, 2015 through January 12, 2016 (23 weeks), but admitted that she was never authorized off of work by any treating physician. Petitioner testified that she never attempted to return to work in any capacity for the Chicago Youth Centers.

Conclusions of Law

As to (C) whether the accident arose out of and in the course of petitioner's employment, the Arbitrator makes the following findings:

The Arbitrator finds that petitioner failed to prove, by a preponderance of the credible evidence, an accident arising out of her employment.

The burden rests with the claimant to prove an injury arising out of her employment. *First Cash Financial v. Industrial Comm'n*, 367 Ill.App.3d 102 (2006). Since the burden of proof is on the petitioner to establish the elements of her claim and right to compensation, 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 Comm'n*, 44 Ill.2d 214 (1969).

In order to determine whether a claimant's injury arose out of her employment, it is first necessary to categorize the risk to which she was exposed. The risks to which an employee may be exposed are categorized into three groups: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal

characteristics. *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill.App.3d 347, 352, 352 (2000). The Arbitrator finds that petitioner was engaged in a neutral risk – i.e. ascending stairs on August 4, 2015 when the injuries occurred.

An injury resulting from a neutral risk, that is one to which the general public is equally exposed, does not arise out of one's employment. The case law is clear that the act of walking up a staircase, by itself, does not expose an employee to a risk greater than that faced by the general public. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409, Ill.App.3d. (2011). An injury caused by a neutral risk is compensable only if the claimant is able to establish that he or she was exposed to the risk at a level higher than members or the general public. The increased risk can either be qualitative, such as some aspect of the employment that contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d, 284.

The Arbitrator finds that petitioner failed to meet her burden of proving that the fall of August 4, 2015 was caused by or related to any employment-related risk. Neither petitioner nor Ms. Staggers identified any defect in the stairs where petitioner fell. Furthermore, petitioner was not performing any employment task at the time of injury and was not carrying any work-related supplies. Moreover, petitioner was assigned to a classroom located on the main level of the Chicago Youth Center and her job duties did not involve frequent traveling up and the down stairs for any reason. Aside from using the restroom, petitioner had no reason to travel up or down the stairs at the Chicago Youth Center. Therefore, the Arbitrator identifies no qualitative or quantitative employment risk that contributed to petitioner's fall.

Petitioner testified that she was walking up the right side of the stairwell when the accident occurred and that Ms. Staggers was walking up the stairs directly behind her on the same side. Petitioner asserted that she lost her balance while turning around to address Ms. Staggers during conversation, which caused her to fall directly backward. In contrast, Ms. Staggers testified that she was walking on the far left side of the stairwell while petitioner was traveling on the far right side. Ms. Staggers stated that the two women proceeded up the stairs at the same pace, traveling side-by-side.

The Arbitrator questions petitioner's version of events, noting that if Ms. Staggers had been traveling directly behind petitioner on the stairwell, and if petitioner fell directly backward, petitioner would almost certainly have taken Ms. Staggers down with her. Neither petitioner nor Ms. Staggers recalled this to be true. The Arbitrator also questions how petitioner could have sustained an injury to her foot while falling backward. Taking these factors into account, the Arbitrator finds Ms. Staggers' testimony to be more plausible and credible.

Even if petitioner's version of the accident was accurate in that she fell due to turning around to address Ms. Staggers in conversation, the act of engaging in conversation while ascending stairs is a risk to which the general public is equally exposed.

Because ascending stairs constitutes a neutral risk to which the general is exposed and because petitioner failed to show any employment risk related to her fall, the Arbitrator finds that petitioner

failed to prove, by a preponderance of the credible evidence, an accident arising out of her employment. The Arbitrator finds that the act of stumbling up the stairs could have only been caused by the Petitioner's own inattentiveness.

As to (F) whether petitioner's current condition of ill-being is causally-related to the injury, the Arbitrator makes the following findings:

In light of the Arbitrator's decision that petitioner failed to prove a compensable accident by a preponderance of the credible evidence, the Arbitrator finds that her current condition is NOT related to her employment with Respondent.

As to (J) whether Respondent paid reasonable and related medical charges, the Arbitrator finds the following:

As petitioner failed to prove, by a preponderance of the credible evidence, an accident arising out of her employment, medical benefits shall NOT be awarded.

As to (K) TTD Benefits, the Arbitrator makes the following findings:

Petitioner failed to prove, by a preponderance of the evidence, an accident arising out of her employment. Therefore, TTD benefits shall NOT be awarded.

Even if petitioner did meet her burden of establishing a compensable accident, the Arbitrator notes that a claimant is not entitled to TTD benefits without medical documentation that she was authorized off of work or received restrictions that the employer was unable to accommodate.

Petitioner testified that she remained off of work from August 5, 2015 through January 12, 2016. On cross-examination, petitioner admitted that she was, in fact, never authorized off of work, but voluntarily chose not to return to work. Likewise, there is no indication in the medical records that petitioner was authorized off of work by any treating physician after the accident or even that she received light duty restrictions. As petitioner failed to prove a compensable accident and did not present any evidence of off-work authorizations, the Arbitrator finds that TTD benefits shall not be awarded.

As to (L), the nature and extent of the injury, the Arbitrator makes the following findings:

The Arbitrator finds that petitioner is not entitled to an award for permanent partial disability as she failed to prove, by a preponderance of the evidence, an accident arising out of her employment.

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

Antonia N. Raglin,
Petitioner,

vs.

NO: 16WC 16070

18IWCC0565

Illinois Department of Juvenile Justice,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 2018, 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: SEP 19 2018
d91118
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAGLIN, ANTONIA N
Employee/Petitioner

Case# **16WC016070**

IL DEPT OF JUVENILE JUSTICE
Employer/Respondent

18IWCC0565

On 3/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% 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:

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA CT
MARYVILLE, IL 62062

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

6137 ASSISTANT ATTORNEY GENERAL
CORI STEWART
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAR 20 2018

DONALD A. RARRIA, Acting Secretary
Illinois Workers' Compensation Commission



STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Antonia N. Raglin
Employee/Petitioner

v.

IL Dept of Juvenile Justice
Employer/Respondent

Case # 16 WC 16070

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on February 23, 2018. By stipulation, the parties agree:

On the date of accident, October 13, 2015, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $58,540.56; the average weekly wage was $1,125.78.

At the time of injury, Petitioner was 40 years of age, married, with 4 dependent child(ren).

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

Respondent shall be given a credit of $3,538.30 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,538.30. The parties stipulated that TTD benefits were paid in full.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $675.47 per week for 25 weeks because the injury sustained caused the five percent (5%) loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

March 16, 2018
Date

MAR 20 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on October 13, 2015. According to the Application, Petitioner sustained an injury to her neck as a result of an auto accident (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that medical and temporary total disability benefits had been paid in full and that the only disputed issue was the nature and extent of disability (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a juvenile parole officer. Petitioner's job required her to visit/counsel parolees, go to various hearings, etc. Petitioner was assigned a number of southern Illinois counties which included Madison and St. Clair counties. Petitioner testified she had to spend a significant amount of time traveling which could be as much as six hours per day. Petitioner would sometimes drive, but there were also occasions in which Petitioner would ride as a passenger with another parole officer driving.

On October 13, 2015, Petitioner was a passenger in a car that was being driven by another parole officer. The vehicle got rear ended by a semi truck which caused Petitioner to sustain injuries to the neck, mid back and low back.

Following the accident, Petitioner was treated at the ER of Belleville Memorial Hospital. At that time, Petitioner complained of left lateral neck pain and stiffness in the mid and low back. X-rays of the cervical spine were obtained which were negative for fracture, but revealed multilevel cervical spondylosis. Petitioner was diagnosed with a cervical strain, prescribed medication and instructed to seek medical treatment from her family physician, Dr. Kristen Stabell (Petitioner's Exhibit 2).

Dr. Stabell initially evaluated Petitioner on October 19, 2015, and Petitioner's primary complaint was in regard to her neck. On examination, the range of motion of Petitioner's neck was limited. Dr. Stabell prescribed medication and referred Petitioner to Dr. Geoffrey Bemis, a chiropractor (Petitioner's Exhibit 3).

When Dr. Stabell subsequently saw Petitioner on November 2, 2015, Petitioner had muscular spasm in the neck as well as mid and low back pain. She noted Petitioner had been seen by Dr. Bemis, but also ordered physical therapy. Petitioner received physical therapy from November 2 through December 3, 2015 (Petitioner's Exhibits 3 and 5).

Dr. Bemis initially saw Petitioner on October 21, 2015. At that time, Petitioner had symptoms in the cervical, thoracic and lumbar spines. Dr. Bemis treated Petitioner primarily with electrical stimulation and heat and periodically saw Petitioner through December 4, 2015 (Petitioner's Exhibit 4).

Petitioner continued to be seen by Dr. Stabell and her condition gradually improved. On November 24, 2015, Petitioner advised she had no pain problems with the low back, but still had mid back and neck pain. Dr. Stabell released Petitioner to return to work without restrictions the following day, November 25, 2015 (Petitioner's Exhibit 3).

Petitioner was able to return to work when released by Dr. Stabell, but was again seen by her on January 22, 2016, because of thoracic back pain. Dr. Stabell again referred Petitioner to Dr. Bemis for further chiropractic treatment (Petitioner's Exhibit 3).

Dr. Bemis subsequently saw Petitioner on February 3, March 16, and September 3, 2016, for cervical, thoracic and lumbar spine complaints. When seen on September 3, 2016, Petitioner advised that her symptoms were aggravated by activities of daily living such as laundry, cleaning or driving/riding in a car (Petitioner's Exhibit 4).

At trial, Petitioner testified she still has complaints of tightness/stiffness in the neck, especially when she looks down. Petitioner does have to look down on a regular basis while at work when she is using her laptop computer. Petitioner also stated she still has mid and low back symptoms associated with activity. In particular, Petitioner's low back soreness/stiffness is something she experiences on a daily basis when she rides in a car. Petitioner has limited her exercising, but has not sought any medical/chiropractic treatment since September, 2016.

Conclusion of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked as a juvenile parole officer, a job which required a significant amount of travel in an automobile. Petitioner continues to experience soreness/stiffness in her low back when she rides in a car. Petitioner's job also requires her to use a laptop computer. When Petitioner looks down to use her laptop, she continues to experience neck symptoms. The Arbitrator gives this factor significant weight.

Petitioner was 40 years old at the time of the accident and will have to live with the effects of the injury for the remainder of her working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence that the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical treatment records clearly indicated that Petitioner sustained a soft tissue injury to the cervical, thoracic and lumbar spines. Petitioner continues to have symptoms in all three areas of the spine consistent with the injury she sustained. When last seen by Dr. Bemis, Petitioner stated that her symptoms were aggravated by activities of daily living, including driving/riding in a car an activity Petitioner does have to engage in on a regular basis in connection with her employment. The Arbitrator gives this factor significant weight.

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 PEORIA	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rodney Fletcher,
Petitioner,

vs.

NO: 15WC 9499

18IWCC0566

Woodford County Sheriff's Department,
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 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 15, 2017, is hereby affirmed and adopted.

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

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

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

SEP 19 2018

DATED:
o091118
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

FLETCHER, RODNEY
Employee/Petitioner

Case# **15WC009499**

WOODFORD COUNTY SHERIFF'S DEPT
Employer/Respondent

18IWCC0566

On 12/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2337 INMAN & FITZGIBBONS LTD
MICHAEL S BANTZ
301 N NEIL ST SUITE 350
CHAMPAIGN, IL 61820

18IWCC0566

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RODNEY FLETCHER,
Employee/Petitioner

v.

WOODFORD COUNTY SHERIFF'S DEPARTMENT,
Employer/Respondent

Case # **15** WC **9499**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **11/16/17**. 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. [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, **12/30/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$45,250.92**; the average weekly wage was **$870.21**.

On the date of accident, Petitioner was **47** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

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

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral hands and bilateral elbows that arose out of and in the course of his employment by respondent on 12/30/14. Petitioner's claim for compensation is denied.

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

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

Maureen H. Pulia

Signature of Arbitrator

12/5/17
Date

ICArbDec19(b)

DEC 15 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 47 year old Deputy Sheriff (correctional officer), alleges he sustained accidental injuries to his bilateral hands and elbows that arose out of and in the course of his employment by respondent, and manifested itself on 12/30/14.

This case was heard in consolidation with case 14 WC 42577 in which petitioner sustained an injury to his right shoulder that arose out of and in the course of his employment by respondent on 7/2/14. The sole issue in dispute with respect to that case is the nature and extent of the petitioner's right shoulder injury. A separate decision has been issued for case 14 WC 42577.

Petitioner has worked part time for respondent for 12 years, and full time for 7 years. Petitioner testified that he worked 8-10 hours a day, 5 days a week. Petitioner testified that his duties included patrol and jail duties. Petitioner testified that he would work patrol 2 days a week, and in the jail 3 days a week. After July 2014 petitioner only worked in the jail.

Petitioner testified that while working patrol his duties included serving papers, handling calls, arresting people, issuing traffic citations, and searching people. Petitioner stated that the duties involving the use of his hands while working patrol included driving with the left arm; using the computer with his right hand; answering the radio with his right hand; serving papers; arresting people with a warrant; cuffing people he arrested; searching the people he arrested; putting arrestees in the squad car; using the computer to enter license plate numbers; writing citations; and writing 1-10 end of day reports.

While working in the jail petitioner's hand intensive duties involved operating the computer with the use of a mouse, touching the screen, and typing; opening doors using a key or the computer; answering phone calls; looking up warrants on the computer; patting people down in the jail; searching inmates and their cells; using the computer to log stuff in and book inmates; writing down different things; filling out different forms; giving inmates their prescriptions; and answering the radio. Petitioner would also escort inmates around the jail. Petitioner would book 1-2 inmates a day, or 5-12 a week. Petitioner would also check mail, work on coordinating visits with clergy and inmate lawyers, monitor feeds, and schedule court dates for inmates.

Petitioner testified that he used the computer from 1 to 4 hours a day with his arms at a 90 degree angle. Petitioner also testified that he would grab doors to open and close them.

When petitioner searched people he would start with the right side of the body and work his hand down the body and in the pockets. He would then do the same with the left side. At times he would also grab the hands of the person while searching them.

When petitioner booked people he would write stuff on paper. He would also enter the person's demographic and charge information, and differentiating marks on the body, into the computer. He also fingerprinted the inmates and took pictures of them. If a person bonded out he would complete the form for that.

When petitioner presented on 7/3/14 to Bloomington Primary Care following an unrelated right shoulder injury, petitioner complained of some pain in the right elbow, and some numbness and tingling in his right forearm. He was assessed with lateral epicondylitis of the right elbow.

On 7/23/14 petitioner returned to Bloomington Primary Care for his right shoulder and elbow. He reported a lot of pain. He stated that he was going to physical therapy and had not found it helpful. Petitioner reported that he was using a tennis elbow strap without improvement. An injection for the right elbow was ordered and petitioner was referred to orthopedics.

On 8/5/14 petitioner presented to Dr. Seidl for his right shoulder and again reported some right elbow pain. Dr. Seidl was of the opinion that petitioner's symptoms were consistent with a tear of the lateral epicondylar musculature. Dr. Seidl assessed right elbow lateral epicondylitis and injected the right elbow. Petitioner was given an elbow strap. On 8/13/14 petitioner reported that he had 50% improvement after the right elbow injection. He stated that he was using the elbow brace.

On 12/30/14 petitioner returned to Dr. Seidl and reported right elbow pain for the past 4 weeks. He reported that his right elbow hurt before he had any symptoms in his right shoulder in July of 2014, then it got better, and then he had symptoms 4 weeks ago. Petitioner reported numbness and tingling in both wrists, hands and forearms. Dr. Seidl was of the opinion that petitioner's symptoms were consistent with possible carpal tunnel and cubital tunnel. Dr. Seidl ordered an EMG/NCV of both hands. He assessed probable bilateral carpal tunnel. In an addendum, Dr. Seidl noted that petitioner had bilateral numbness in his digits, mostly consistent with carpal tunnel, positive Tinel's, carpal tunnel compression and Phalen's on both wrists. Dr. Seidl noted that petitioner's conditions are aggravated by his work activities. He was of the opinion that it is not unusual for symptoms such as these to be aggravated by repetitive work activities. Therefore, Dr. Seidl felt that petitioner's symptoms were work related because petitioner reported that his work activities made his symptoms worse.

On 1/14/15 petitioner returned to Dr. Seidl with complaints of right elbow pain for 2 years. He reported a constant dull ache that was tender to the touch. Dr. Seidl ordered an MRI of the right elbow.

On 3/26/15 petitioner underwent a Section 12 examination by Dr. Lawrence Li, at the request of the respondent. He identified petitioner's main duties as escorting inmates, opening doors, typing, and applying handcuffs as needed. He provided a consistent history of an injury on 7/2/14. Dr. Li performed a record review. Petitioner reported that he was full duty since Halloween 2014, and was doing well at work. He also reported that sometime after the surgery for his right shoulder he developed some numbness and tingling in his hands, maybe about the end of September of 2014, and reported it to Dr. Seidl on 12/30/14. Petitioner also reported unrelated left shoulder pain for which he underwent an injection. Petitioner noted fishing as a hobby. He reported some occasional pain in his right elbow that is generally very tolerable unless he bumps it.

Following his record review, history and examination, Dr. Li noted petitioner's job duties as unlocking doors to the cell, handcuffing inmates, taking inmates where they need to go, and then locking the door again. He also noted other duties as typing, and opening doors. Dr. Li was of the opinion that these were the major job duties relevant to petitioner's upper extremities. Dr. Li was of the opinion that petitioner's complaints of numbness and tingling in his hands are relatively vague and consistent with the reports that he made with respect to Dr. Seidl's notes. He also complained of pain over the lateral aspect of the right elbow, consistent with what he had complained of with Dr. Seidl. Dr. Li found no abnormalities on his objective exam. He noted that petitioner had some subjective pain with tenderness to palpation on the lateral aspect of the right elbow that was aggravated with extension of the wrist. Dr. Li found no objective loss or dysfunction in his right hand. Dr. Li diagnosed petitioner with right lateral epicondylitis, and noted that it is possible petitioner has carpal tunnel syndrome, right worse than left. Dr. Li was of the opinion that if petitioner has carpal tunnel syndrome it is not related to his job duties because his job duties simply are not repetitive enough and do not cause strain on the wrist, and do not cause excessive stress on the wrist to result in carpal tunnel syndrome. He noted that petitioner's right elbow was temporarily aggravated and resolved. Dr. Li was of the opinion that petitioner has reached maximum medical improvement and was not in need of any further medical treatment. Dr. Li was of the opinion that with complaints of numbness and tingling an EMG would be reasonable, but is not related to the 7/2/14 incident. Dr. Li was of the opinion that petitioner's right shoulder and right elbow treatment to date was reasonable and necessary as it relates to the injury on 7/2/14. He opined that any carpal tunnel treatment or testing would not be related to the 7/2/14 injury.

Petitioner did not return again to Dr. Seidl until 7/10/15. At that time he reported that he still had right elbow pain, and tingling in his right hand for 10-12 months. Petitioner denied any issues before the injury on 7/2/14 where he injured his right shoulder dumping a heavy load of laundry into a bin. He reported that the symptoms in his right hand are limited to the first 4 fingers of the right hand. He also reported some pins and needles sensation and some transient numbness in the right hand, which seemed to be related to activity, such as reading, driving, and talking on the phone. He also reported pain in the lateral aspect of the right elbow even doing simple activities such as drinking a cup of coffee, getting a jug of milk out of the refrigerator, or any kind of lifting or twisting type of motions. He reported that increased activity causes increased pain and symptoms into both the right elbow and hand. Dr. Seidl noted that petitioner was overweight and used a walker for ambulation. The only positive finding was the Phalen's test into the first 3 fingers of the right hand, discomfort in the right lateral aspect, and positive Tinel's at the right elbow. An x-ray of the right wrist showed slight degenerative changes at the CMC joint of the thumb. An x-ray of the right elbow showed calcific tendonitis over the lateral aspect of the elbow. Dr. Seidl assessed carpal tunnel syndrome of the right upper extremity and calcific tendonitis/lateral epicondylitis of the right elbow. An EMG/NCV of the right upper extremity was ordered.

On 1/14/16 petitioner returned to Dr. Seidl and reported ongoing pain in the left elbow since 7/2/14. An MRI of the right elbow was ordered. Dr. Seidl noted that petitioner needed a carpal tunnel release.

On 4/6/17 the evidence deposition of Dr. Li was taken on behalf of respondent. Dr. Li opined, after reading petitioner's job duties, that petitioner has a very wide variety of tasks that he would have to perform at his job. He opined that the nature of having a wide variety of tasks is contrary to the idea that he had a singular repetitive task that he performed. Dr. Li was of the opinion that lateral epicondylitis is a degeneration of the extensor tendon which elevates the wrist, and cubital tunnel is compression of the ulnar nerve, or nerve compression syndrome, and that they are not related, and are on different sides of the arm. Dr. Li opined that he did not diagnose petitioner with cubital tunnel. Dr. Li opined that any carpal tunnel or cubital tunnel petitioner may have was not caused, accelerated, or aggravated by his work duties. Dr. Li further opined that petitioner's job duties were not repetitive in nature. Dr. Li opined that petitioner was morbidly obese, a smoker, and older, and people who are morbidly obese, smokers, or older are more likely to develop carpal or cubital tunnel. Dr. Li opined that typing, in and of itself, does not cause, aggravate, or accelerate carpal or cubital tunnel syndrome.

On cross examination, Dr. Li opined that if petitioner spent 40% of his day typing with his wrists flexed or extended to 40 degrees or more doing a single activity, then that would be something that could cause or aggravate carpal tunnel syndrome.

On 6/8/17 the evidence deposition of Dr. Seidl was taken on behalf of the petitioner. His diagnosis of petitioner's right upper extremity was carpal tunnel and lateral epicondylitis. He testified that he had not seen petitioner for awhile, but if his symptoms were still present he would want an EMG, and if the EMG confirmed the carpal tunnel he would order a carpal tunnel release. He further stated that if petitioner still had symptoms in the elbow he would recommend an excision debridement and release of the lateral epicondyle. Dr. Seidl was of the opinion that petitioner's right upper extremity injury on 7/2/14 aggravated or caused, to some degree, petitioner's pain and discomfort.

On cross examination Dr. Seidl was of the opinion that medial epicondylitis is on the same side of the elbow in a very basic sense, and cubital tunnel is due to the ulnar nerve entrapment at the cubital tunnel of the elbow. He was of the opinion that cubital tunnel is a nerve problem and epicondylitis is the epicondylar pain due to the tendon insertion and the injury that is caused on the tendon, on the bone. He testified that the injection petitioner underwetn was not for cubital tunnel, but rather for epicondylitis. Dr. Seidl testified that he has not yet diagnosed petitioner with cubital tunnel. Dr. Seidl was of the opinion that petitioner performed repetitive activities such as pulling and pushing. Dr. Seidl was not sure exactly what petitioner does, but believed he performed repetitive activities because petitioner told him. He testified that all his information regarding petitioner's job duties was what petitioner told him. He testified that he really did not get into petitioner's specific duties. Dr. Seidl did not know if escorting inmates was part of petitioner's job duties. He also did not know if petitioner typed and the frequency of it, or if petitioner monitored surveillance cameras, cleaned the jail, checked mail, booked new inmates, coordinated visits to detainees, transported detainees and their paperwork, performed cell inspections, or woke up inmates. Dr. Seidl admitted that he did not know petitioner's specific job duties, or their frequency. Dr. Seidl testified that he knew petitioner was a jailer and that he did not sit at a desk with his arms tied. Dr. Seidl did not believe knowing all of petitioner's job duties and the frequency of knowing them was relevant. Dr. Seidl agreed that people that are morbidly obese or smoke are more likely to develop carpal and cubital tunnel. He also testified that petitioner is morbidly obese.

Petitioner offered into evidence a job description for a Correctional Officer. The duties included:

1. take charge of detainees and do such tasks as are necessary to properly process detainees into the jail facility such as fingerprinting, photographs, searching, securing personal property of detainee, etc.;

2. attend to detainees well being (physical safety, hygiene, medical needs including examination, prescriptions, etc.);
3. ensure jail facilities are kept in a clean, neat, and safe manner;
4. receive and check incoming and outgoing inmate mail;
5. responsible for all details of inmate visitation, including clergy and attorney visits;
6. receive and properly care for bail bond and assign court dates consistent with orders of the Court;
7. transport detainees and required paperwork to and from Court, as required;
8. maintain physical security of jail;
9. operate the prisoner commissary, as directed.

Petitioner also offered into evidence the job description for Post Orders. The general duties for booking included:

1. responsible for receiving, processing, retaining and releasing of all persons admitted to the facility;
2. collection of biographical and physical data; fingerprinting, and photographing of person admitted to the facility;
3. maintain custody of person being held pending identification, issuance of warrants, and processing of bonds;
4. conduct security checks on inmates held in the booking area, holding, padded, and detox cells;
5. complete filing and upkeep of records. All documents need to be maintained according to policy and procedure. Booking officer should ensure all paperwork is filed and managed to avoid loss or misplacement of records;
6. transport prisoners to court and document court activities upon return;
7. document via jail log all activities in the booking area, including new prisoner names and charges, transfer or release of prisoners, work release documentation and records maintenance;
8. assisting in other areas of the facility when needed.

The general duties for tower included:

1. responsible for the safety of inmates, staff, and security of the facility. Conduct and record all formal and 30 minute security checks for the housing area;
2. conduct or assist in the inspection of cells and shakedowns;
3. conduct wakeup for prisoners. The inmates will be unlocked starting at 0630 hours;
4. the Correctional Officer assigned to housing will ascertain which inmates are to have access to the dayroom. All cells will be inspected as cell doors are open. One pod will be done at a time and there will always be two officers in housing when this is done;
5. No unoccupied cells will be unlocked;
6. Shaves will be conducted before inmates are unlocked in the morning;
7. There will be shaving cream and razors provided for those desiring to shave;
8. the officer will be responsible for securing all shaving supplies no later than 0700 hours;
9. the officer will ensure that all shaving equipment is intact;
10. all razors and shaving cream must be accounted for at 0630 hours;

11. those inmates that are emotionally disturbed, or who are likely to misuse the razor will be personally observed by an officer while shaving;
12. all razors will be inspected and accounted for prior to disposal. All razors will be disposed of in the biohazard waste container in the housing area;
13. transport/escort prisoners to sick call, attorney visits, religious meetings, recreation, and visitation;
14. distribute medications;
15. distribute cleaning supplies and monitor daily cleaning of cell block;
16. serve and pick up meal trays, make sure number of trays going in come out;
17. collection of inmate requests and grievances and distribution to appropriate place;
18. officer is responsible for tending to needs of each individual inmate within reason, and ability;
19. log, inspect, and distribute inmate mail per policy and procedure;
20. maintain a written and computerized record of all activities of the inmate population and housing areas.

The general duties for central control included:

1. central control id specifically designed to contain the electronic control panels, surveillance systems, fire alarms system, and other security equipment. It must be staffed 24 hours a day.
2. maintaining the overall security of the facility;
3. ensuring central control and all other security doors remain locked at all times except for entrance and exit;
4. restrict access to central control to authorized personnel;
5. distribution and inventory, via key log, of all security keys at the beginning and end of the shift.
6. monitor all areas of facility with surveillance cameras, verifying the identity and purpose of the persons;
7. answering all phone calls with courtesy and provide the public and other agencies with authorized information;
8. contacting dispatch when there is an emergency or a need for assistance, or if it is necessary to page maintenance or the sheriff; maintain the jail log for juveniles while in custody;
9. maintain a clean, well organized area where information can be easily locked.

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

Petitioner is alleging an injury to his bilateral hands and bilateral elbows due to repetitive work activities, that arose out of and in the course of his employment by respondent and manifested itself on 12/30/14.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers'

Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming injuries to his bilateral hands and bilateral elbows, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

In the case at bar, petitioner's manifestation date of 12/30/14 is the date petitioner presented to Dr. Seidl and reported right elbow pain for the past 4 weeks. Petitioner also reported numbness and tingling in both wrists, hands, and forearms. On this date, Dr. Seidl noted that petitioner's conditions were aggravated by his work activities.

Petitioner has worked part time for respondent for 12 years, and full time for 7 years as a Correctional Officer. Petitioner's duties included patrol duties 2 days a week, and jail duties 3 days a week through July of 2014. After July of 2014 petitioner's duties were all performed in the jail.

When proving up an injury due to repetitive work activities it is imperative that the petitioner place into evidence specific and detailed information concerning his work activities, including the frequency, duration, manner of performing, etc. In the case at bar, petitioner testified at trial that his duties while on

patrol 2 days a week included serving papers, handling calls, arresting people, issuing traffic citations, and searching people. Petitioner stated that the duties involving the use of his hands while working patrol included driving with the left arm; using the computer with his right hand; answering the radio with his right hand; serving papers; arresting people with a warrant; cuffing people he arrested; searching the people he arrested; putting arrestees in the squad car; using the computer to enter license plate numbers; writing citations; and writing 1-10 end of day reports.

While working in the jail 3 days a week before July 2014, and 5 days a week after July 2014, petitioner's hand intensive duties involved operating the computer with the use of a mouse, touching the screen, and typing; opening doors using a key or the computer; answering phone calls; looking up warrants on the computer; patting people down in the jail; searching inmates and their cells; using the computer to log stuff in and book inmates; writing down different things; filling out different forms; giving inmates their prescriptions; and answering the radio. Petitioner also escorted inmates around the jail. Petitioner would book 1-2 inmates a day, or 5-12 a week. Petitioner would also check mail, work on coordinating visits with clergy and inmate lawyers, monitor feeds, and schedule court dates for inmates while working in the jail.

Petitioner testified that he used the computer from 1 to 4 hours a day with his arms at a 90 degree angle, but did not indicate if this use of the computer was while he was on patrol or in the jail, or if it was continual. Petitioner also testified that he would grab doors to open and close them, but again did not indicate the frequency or manner in which he performed these duties.

Petitioner testified that when he searched people he would start with the right side of the body and work his hand down the body and in the pockets. He would then do the same with the left side. At times he would also grab the hands of the person while searching them.

Petitioner testified that when he booked inmates he would write stuff on paper. He would also enter the persons demographic and charge information, and differentiating marks on the body into the computer. He also fingerprinted the inmates and took pictures of them. If a person bonded out he would complete the form for that.

In addition to the duties petitioner testified that he performed on patrol and in the jail, petitioner also offered into evidence a job description for a Correctional Officer. This job description identified over 37 duties petitioner would perform as a correctional officer when booking, working in the tower, and when in central control.

Of the multitude of job duties petitioner would perform as a Correctional Officer, petitioner only provided the frequency of these duties as it related to writing 1-10 reports at the end of the day, and booking 1-2 inmates a day. Petitioner also testified that he used the computer 1-4 hours a day, but did not state if this was in the patrol car or the jail, and whether or not this use of the computer was continuous for the 1-4 hours. The arbitrator also finds the range of 1-4 hours vague, especially given the fact that it is unknown how many days he was on the computer for an hour versus how many days it was over an hour, up to 4 hours. Since petitioner also testified that used the mouse on the computer, would use the touch screen, and type on the computer, it is unknown how much of the 1-4 hours was spent performing each of these computer tasks rather than simply typing.

With respect to the remaining duties petitioner performed as identified on his job description and those he testified to, the arbitrator finds it significant that petitioner did not place into evidence any specific and detailed information concerning all these remaining work activities, including the frequency, duration, and manner in which he performed them.

In addition to the petitioner placing into evidence specific and detailed information concerning the his work activities, including the frequency, duration, manner of performing, etc., the arbitrator finds it is also imperative that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

In the case at bar, petitioner treated with Dr. Seidl, and was examined by Dr. Li. Although Dr. Seidl opined that petitioner's conditions were aggravated by his work duties, Dr. Seidl was not sure what petitioner actually did, and only believed his duties were repetitive because petitioner had told him they were. Dr. Seidl admitted that the only information he had regarding petitioner's job duties was what petitioner told him. Dr. Seidl did not read petitioner's job description, did not know if petitioner escorted inmates, did not know if he typed and the frequency of it, and did not know if petitioner monitored surveillance cameras, cleaned the jail, checked mail, booked new inmates, coordinated visits to detainees, transported detainees and their paperwork, performed cell inspection, or woke up inmates. Dr. Seidl also testified that he did know all petitioner's job duties or the frequency with which petitioner performed these duties. For these reasons the arbitrator does not find Dr. Seidl's opinions persuasive, since Dr. Seidl clearly did not have a detailed and accurate understanding of the petitioner's work activities.

In the alternative, Dr. Li examined petitioner at the request of respondent. Petitioner identified his main duties as escorting inmates, opening doors, typing, unlocking and locking doors to the cells, and applying handcuffs as needed. In addition to the job duties as described by petitioner, Dr. Li also read petitioner's job duties as a correctional officer, as described on his job description. Based on these descriptions, Dr. Li was of the opinion that petitioner had a very wide variety of tasks that he performed as part of his job. Dr. Li opined that the nature of having a wide variety of tasks is contrary to the idea that he had a singular task that he performed continually. Dr. Li opined that petitioner's duties were not repetitive in nature. For these reasons, the arbitrator finds the opinions of Dr. Li more persuasive than those of Dr. Seidl, especially given the fact that Dr. Li had a detailed and accurate understanding of petitioner's work activities.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral hands and bilateral elbows that arose out of and in the course of his employment by respondent on 12/30/14. The arbitrator bases this finding on the fact that petitioner had over 37 different duties as part of his job as a Corrections Officer; that petitioner failed to place into evidence specific and detailed information concerning the his work activities, including the frequency, duration, and manner in which he performed them, etc.; and that Dr. Seidl, who was the only doctor who related petitioner's conditions to his work duties, admitted that he did not have a detailed and accurate understanding of petitioner's work activities.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral hands and bilateral elbows that arose out of and in the course of his employment by respondent on 12/30/14, the arbitrator finds these remaining issues moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Grobe,
Petitioner,
vs.

NO: 15WC 22676

18IWCC0567

Johnson Machine Works, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical, 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 28, 2017, is hereby affirmed and adopted.

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

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

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

DATED: SEP 19 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GROBE, JEFF
Employee/Petitioner

Case# **15WC022676**

JOHNSON MACHINE WORKS INC
Employer/Respondent

18IWCC0567

On 9/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

0210 GANAN & SHAPIRO PC
COURTNEY QUILTER
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

18IWCC0567

☐ 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 GROBE
Employee/Petitioner

v.

JOHNSON MACHINE WORKS, INC.
Employer/Respondent

Case # **15** WC **22676**

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 **Ottawa, Illinois**, on **8/28/17**. 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 _____

FINDINGS

On **6/12/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,687.32**; the average weekly wage was **$570.91**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **1** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$342.55**/week for **52.25** weeks, because the injuries sustained caused the Petitioner **15% loss of use of the left hand (28.5 weeks) and 12-1/2% loss of use of the right hand (23.75 weeks),** as provided in Section 8(e)9 of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $435.76 to OSF Medical Group, $975.56 to OSF St. Elizabeth Medical Center, and $493.54 to Dr. Garg, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall reimburse Petitioner $101.21 for reasonable and necessary out-of-pocket medical expenses, and Respondent shall hold Petitioner harmless from any repayment obligations of his personal insurance for bills it paid relative to this matter.

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

9/25/17
Date

SEP 28 2017

18IWCC0567

FINDINGS OF FACT:

Petitioner, Jeff Grobe, began working as a machine operator for Respondent, Johnson Machine Works, Inc., in February of 2009. His job duties included loading and unloading, packing, and deburring. Petitioner testified he operated the Moni Seiki mill. Petitioner testified that he began by loading the milling machine using both hands to lift a part shoulder height to the machine. He then secured the part in the machine by holding it with one hand and screwing it in with the other using a ½" impact wrench with 90 lbs. of pressure. Petitioner indicated this process was highly vibratory due to the use of the impact wrench and required that he maintain a tight grip with both hands. After repeating this process for 3 more parts, Petitioner would start the machine. While the Moni Seiki ran, Petitioner was required to deburr four cast iron parts using an air powered grinder. With the grinder in one hand and the part in the other, Petitioner would grind the rough edges of each part to obtain a smooth surface. After grinding, Petitioner would use both hands to inspect the piece and remove any rust using a handheld air-powered wire wheel.

Petitioner testified he spent 85% of his day wrenching, grinding, deburring, and otherwise using handheld power tools. He would typically work from 6am to 2pm, without taking lunch. He reported the only time his hands were not in constant movement was during his break from 9:00-9:10am. Petitioner stated his job duties essentially remained the same throughout his employment.

Petitioner testified that in early 2015, he orally reported having tingling and soreness throughout both arms from wrist to shoulder to Stan Dale, Respondent's then owner and general manager. Petitioner testified his problems had developed over the course of two years. It began as tingling in both wrists, then soreness in his forearms and discomfort in his shoulders. He attempted to treat his pain by taking 800mg of ibuprofen twice daily. In April of 2015, Petitioner was moved to the Ukoma lathe machine. Petitioner stated his repetitive activities and use of vibratory tools did not change and he continued to experience bilateral arm pain. Petitioner testified that on June 12, 2015, he again reported his problems to Respondent by submitting a written report.

On June 15, 2015 Petitioner sought treatment with Dr. Jasime Bhugri at OSF St. Elizabeth Hospital. On that date, Dr. Bhugri noted Petitioner had been doing repetitive work and had gradually worsening numbness, tingling, and pain in bilateral hands and arms. Petitioner reported that his numbness and tingling was worse in the thumb, index, middle and ring fingers. Upon physical examination, Dr. Bhugri noted Petitioner had positive Phalen's and Tinel tests in both arms, along with elbow discomfort and tenderness. Dr. Bhugri diagnosed Petitioner with bilateral carpal tunnel syndrome and referred him to Dr. Garg, a neurologist, for evaluation and a nerve conduction study (NCV). (PX 2) The NCV and EMG study when conducted on June 19, 2015 suggested mild bilateral carpal tunnel syndrome and normal radial and ulnar nerve on both sides. (PX 3)

Petitioner followed with Dr. Bhugri on June 22, 2015. The doctor reviewed the test results indicating same confirmed Petitioner's diagnosis of bilateral carpel tunnel syndrome. Dr. Bhugri referred Petitioner to Dr. Ho for orthopedic care. (PX 2) Petitioner testified he was terminated by Respondent shortly thereafter after reporting his concern involving a safety issue.

On July 16, 2015, Petitioner presented to Dr. Emmy Ho with complaints of ongoing bilateral wrist numbness and tingling, forearm and elbow pain and numbness as well as shoulder and mid-upper back pain. Dr. Ho noted Petitioner was a machinist that did repetitive heavy lifting and used air impact tools and grinders before being terminated on June 29, 2015. Following a physical examination, Dr. Ho diagnosed Petitioner with chronic elbow pain, bilateral carpal tunnel syndrome and bilateral shoulder pain. Dr. Ho noted that Petitioner

had diffused symptoms likely overuse. The doctor provided Petitioner with a Medrol dose pack for inflammation and referred him to Occupational Therapy for treatment of the carpal tunnel syndrome. (PX 2) On July 22, 2015, occupational therapy provided Petitioner with tendon glides and bilateral wrist cock-up splints for use at night. (PX 4)

Petitioner followed with Dr. Ho on August 10, 2015. Dr. Ho noted Petitioner's shoulder no longer bothered him but he continued to have numbness and tingling in all fingers except the pinky in both hands. His symptoms were worse with use and caused him to drop tools when working. Also noted was that Petitioner's symptoms kept him up at night. Petitioner reported little relief from the steroids or use of night splints. Dr. Ho recommended bilateral carpal tunnel surgery. (PX 2)

Petitioner proceeded to undergo a left carpal tunnel release on August 14th and a right carpal tunnel release on August 28, 2015. (PX 4) Petitioner testified that his symptoms had completely resolved approximately four weeks after surgery.

At Respondent's request, Petitioner saw Dr. Michael Vender for an Independent Medical Evaluation (IME) on August 31, 2015. Dr. Vender's report dated September 1, 2015, notes that Petitioner was a 57-year-old that developed numbness and tingling in both hands and pain in both shoulders and elbows over the course of the previous 3-4 years. He was diagnosed as having bilateral carpal tunnel syndrome and underwent a carpal tunnel release on the left on August 14, 2015, and on the right on August 28, 2015. Dr. Vender noted that Petitioner reported a marked improvement in his preoperative symptoms since surgery. (RX 5)

Dr. Michael I.Vender opined that Petitioner's history of complaints and medical history were consistent with bilateral carpal tunnel syndrome. Dr. Vender's report indicates that Respondent provided him with a written job description for a CNC Machine Operator (See RX 1), a CNC Machine Operator job analysis report dated 7/25/15 (See RX 3), and a videotape labeled Johnson Pattern & Machine, Machine Operator, 7/27/15. (See RX 2) Dr. Vender was asked by Respondent to opine as to 1.) whether the activities performed in the video are repetitive in nature; 2.) explain any signs of symptom magnification and 3.) did he detect any inconsistencies in the medical records he reviewed. Dr. Vender responded indicating, "The video demonstrates normal use of the hands and upper extremities. There are no significant repetitive activities. There is only very limited exposure to forces. These activities would not be contributory to the development of carpal tunnel syndrome." The doctor provided that he did not identify any inconsistencies or signs of symptom magnification. Nor did he identify any inconsistencies in the medical records. Dr. Vender further opined that Petitioner would reach maximum medical improvement approximately three months after each carpal tunnel release and, other than postoperative occupational therapy, no further treatment would be needed. (RX 5)

Dr. Vender also testified via deposition in this matter. Dr. Vender testified that he did not believe there was a causal relationship between Petitioner's job and the development of carpal tunnel syndrome. The doctor stated, "...his job would not be considered repetitive. His job would not be considered forceful. He performs many different types of activities, which precludes the concept of repetitiveness." The doctor added, "A lot of times he wasn't even doing much with his hands,...That's not persistent use or repetitive use. And the activities he demonstrated were of a non-forceful nature...But most importantly it's non-forceful. So even if there were aspects of repetition, there was no significant force demonstrated." (RX 4, pp.13-14)

On cross-examination, Dr. Vender testified that his understanding of Petitioner's job description and his opinions as to causation, were heavily reliant on the truth and accuracy of the job description and the video provided to him by Respondent. Dr. Vender stated that he did not attempt to verify the job description with Petitioner during the examination. (RX 4, pp. 18-19) When asked if his opinions would change if Petitioner's actual job was different than what was portrayed on the video, Dr. Vender stated, "...it would have to be a big

difference in this particular case…if there's something very prominently different, then I would have to reconsider that." (RX 4, pp. 21-22)

On April 5, 2017, Petitioner underwent an Independent Medical Evaluation (IME) by Dr. Robert Eilers. In his IME Report, Dr. Eilers recorded a history that Petitioner worked for Respondent for six years as a production machinist milling 2-6lb cast iron parts. He noted Petitioner would machine, mill, drill, and bore the parts using ratchets and other hand tools. Petitioner would load parts into the machine at shoulder height and above, and use air impact hammers to secure them into position. While his machine ran, Petitioner would engrave and etch numbers into the part, chip grind away any burrs, clean and remove rust using a wire wheel, and prepare additional parts. The doctor noted Petitioner would have to hold the parts in his left hand and then grind them with a right-angle grinder, holding the clasp down continuously while grinding and turning the part. He noted Petitioner would bend, twist, push, pull and turn while he was holding a part and trying to grind it with a high-speed grinder to remove rust. There was no vice to keep the part in a fixed position and Petitioner would have to constantly hold them in his hands. Dr. Eilers stated that after years of doing this work all day, Petitioner noticed his hand began to swell and he started having right elbow tenderness and shoulder pain. He was awakening with it at night, getting numbness and swelling. He started taking Motrin 800 mg three times a day over the counter. This helped with only the elbow for a while, until he began to have bloody stools and had to reduce the amount he was taking. (PX 5)

Dr. Eilers also recorded the history that in April of 2015, Petitioner was placed on a lathe where he worked with 70lb products. He would use a jack to get them in place, then strap them with 1" straps. Petitioner would then have to grind and deburr each part, completing 160 per day. By June 2015, Petitioner returned to his initial job, at which time his problems worsened to the point he could no longer perform the grinding and holding tasks. (PX 5)

After reviewing Petitioner's medical records and work history, Dr. Eilers opined: "The [Petitioner] developed bilateral carpal tunnel syndrome, left and right, as a result of his repetitive work activities at the job. The most significant impact would be holding the cast iron items, the grinding, using the wheels, having to deburr and remove rust which required a great deal of gripping with each hand, and holding tools where you would have to compress the lever and then move it in order to grind the material." The doctor added, "The patient's carpal tunnel syndrome follows an appropriate history and progression of his symptoms. Surgery resolved his more proximal symptoms, and he has had a good result from the surgery which was needed to treat the occupational carpal tunnel syndrome based upon the description of the job." Dr. Eilers noted Petitioner continued to have mild weakness in his left hand grip strength compared to the right as a result of carpal tunnel. (PX 5)

Dr. Eilers also noted that he reviewed the description of the video taken. The doctor wrote that same "…does not identify the deburring, the grinding that is carried out, particularly with his hands – sometimes the drill, but it does not focus on a lot of the grinding, scraping, and deburring that he has to carry out." Dr. Eilers further noted that no job description was provided to Dr. Vender detailing the extensive use of the right-handed drill or extensive use of the wire wheels. The doctor stated, "Certainly, this additional point, plus his regular job would be consistent with the force and the repetitive activity that could cause his carpal tunnel syndrome." (PX 5)

Dr. Eilers opined that Petitioner's treatment to date had been reasonable, appropriate, and necessary to treat his condition of ill-being. Dr. Eilers opined Petitioner's bilateral carpal tunnel syndrome surgery was caused by his work activities, "…and certainly these are a direct and proximate cause of his work activity, particularly in light of the frequent use of grinding, twisting, turning and working with cast iron parts..." Lastly, Dr. Eilers provided that he would not recommend Petitioner returning to repetitive tasks, he felt Petitioner could return to similar work activities, albeit with some limitations due to Petitioner's left hand weakness. (PX 5)

Dr. Eilers also testified via deposition in this matter. Dr. Eilers testimony was consistent with his April 2017 report. Dr. Eilers stated that Petitioner development of bilateral carpal tunnel syndrome and the surgical release thereafter were due to the repetitive work activities he noted in his April 2017 report. (PX 6, pp.15-17) Dr. Eilers testified with respect to his review of the description of the videotape also considered by Dr. Vender. Dr. Eilers stated same "...didn't talk about the grinding, the deburring [and] the bio-manual activity. It talked about whether it's the lathes or the grinder, but it wasn't talking about the individual hand activities he was doing while the equipment was running." The doctor provided that "...the machine equipment itself that he had run wasn't so much of a problem putting it in, but the constant grinding and deburring is what caused the problem in all probability." (PX 6, p.18)

On cross-examination, Dr. Eilers testified that he is not board-certified in orthopedic surgery. He is board certified in physical medicine and rehabilitation. He has no other specialty. (PX 6, pp.24-25) The doctor stated that the weights of the parts, two (2) to six (6) pounds, discussed in his report were weights conveyed by Petitioner. The doctor provided that although he did not have any quantitative information regarding the weights of the tools Petitioner worked with, he was familiar with right-handed grinders and wheels. Dr. Eilers testified that he had no quantitative information regarding the amount of force used to tighten the parts Petitioner worked with, the number of times per day Petitioner would have to tighten parts, the amount of force used to operate air hammers or the number of times Petitioner would have to use an air hammer and the amount of force used to operate the grinder or the number of times Petitioner would have to use a grinder. Regarding the amount of force required to operate a grinder, Dr. Eilers stated, "...if you ever used a grinder, I don't know how to actually put that in mind with force, but they can bounce fairly aggressively. If you do them lightly, you're going to get a lot of bouncing, which is why they do the eye protection, multiple gloves. It's obviously a wire brush. And there's going to be a fair amount of force. I'm not certain what the actual rotational torque – so you have rotational torque with the brush, then you're going to have a downward force with the actual handheld with the grinder. So there are two elements of force. There's one constantly wanting to move the piece your grinding in a more clockwise moment. So if he's holding it in the left, he's going to want to resist moving counterclockwise, because he wants to balance the force between the wire brush and the cast iron that he's doing. And then to reposition it, he's going to hold it with his fingers tightly to reposition to grind the other areas. Then he would have to reposition the whole item to continue grinding." The doctor added that the output of pressure that's required to remove burrs will depend upon the nature of the burr and rust., "...but he's going to apply a fair amount of force to keep that from being thrown out of his hand." (PX 6, pp.27-29)

Petitioner called Mr. Kenneth Katrein to testify. Mr. Katrein testified that he performed the same job tasks as Petitioner during his employment with Respondent from 2012-2014. Mr. Katrein reiterated that the job required use of impact tools for 85% of the day. Mr. Katrein viewed Respondent's video purporting to show Petitioner's job duties twice and testified that it was inaccurate. He indicated that the video only showed one station being loaded with 4 parts, but Petitioner would load two stations so there would be 8 parts. Further, in the video, only the two of the six holes were "champered," indicating the parts had already run through the machine. The video also showed a much slower pace of work. Mr. Katrein further testified that Petitioner complained to him of wrist pain during his employment with Respondent.

Petitioner also called Mr. Kevin Videgar to testify. Mr. Videgar worked for Respondent from May 2015 to June 2016 doing the same work as Petitioner. Mr. Videgar testified that Respondent's video failed to accurately depict all of Petitioner's job duties. Mr. Videgar testified that champering, deburring, grinding and using the wire wheel and air tool were all vibratory. 80-85% of each day was spent using these vibratory tools.

Respondent called Mr. Dale Schubert to testify as a witness. Mr. Schubert has worked for Respondent for 19 years and currently holds the position of general manager. Mr. Schubert stated that Petitioner was a horizontal mill and horizontal lathe machine operator for Respondent. He provided that Petitioner would operate

the lathe machine more often and that Petitioner's job involved loading, unloading, deburring, inspecting, and packing parts of different sizes weighing between 60-70lbs. He stated that each machine cycle takes 7-8 minutes. Mr. Schubert testified that he was present and participated in the video job analysis. He also testified the written job analysis (RX 3) was created at the time of the video job analysis and he helped create the written job analysis as well as the job description. (RX 1; RX 3) Mr. Schubert stated that he reviewed both the video job analysis and written job analysis and confirmed both were an accurate representation of Petitioner's job duties. Finally, he testified that Petitioner never reported any issues with his upper extremities or performing his job. He testified an accident report was never completed and he did not learn of an alleged accident until he was contacted in July 2015 regarding the video job analysis.

On cross-examination, Mr. Shubert testified that he worked with Petitioner from June 9, 2015 until Petitioner was terminated. Petitioner was terminated for problems stemming from "not showing up." Mr. Shubert stated Petitioner complained that the lathe machine was old and missing the safety door and refused to run it. Mr. Shubert agreed that the video does not demonstrate bending/twisting of the hands more than half the time. Mr. Shubert further admitted that the job description (RX 1) indicates Petitioner's job has physical requirements of frequent bending/twisting and frequent gripping/pinching, meaning 75-80% of the time. Mr. Shubert further agreed that Petitioner's job, being production, is repetitive and that deburring is vibratory.

Respondent called Mr. Keith Johnson, president and co-owner of Respondent. Mr. Johnson testified that he supervises employees; he is not a machinist. He agreed that Petitioner accurately described his job duties, except for the cycle time. He stated grinding and deburring have short cycle times and 85% vibratory work is high. Mr. Johnson testified that he took over as president on June 1, 2015, after his brother-in-law Stan Dale retired. Mr. Johnson stated he went through Mr. Dale's records and did not see an injury report in Petitioner's file. With respect to Petitioner's termination, Mr. Johnson said he and Mr. Shubert called Petitioner to discuss attendance and offered to make him part-time. Petitioner was then terminated following an altercation with Mr. Johnson's wife, which upset her.

On cross-examination, Mr. Johnson agreed that that the air tools, grinders, and sanders used by Petitioner during his employment were vibratory.

Petitioner submitted gross medical bills of $25,451.90 (OSF Medical Group: $4,919.00; OSF St. Elizabeth Medical Center: $19,055.90; Central Illinois Radiological Associates: $53.00; Dr. Garg: $1,424.00). (PX 1) Of this amount, Petitioner's personal insurance paid $20,246.99, Petitioner paid $101.21 out of pocket, and $1,904.86 remains outstanding (OSF Medical Group: $435.76; OSF St. Elizabeth Medical Center: $975.56; Dr. Garg: $493.54).

With respect to C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; F.) Is Petitioner's current condition of ill-being causally related to the injury; and E) Was timely notice of the accident given to Respondent, the Arbitrator finds as follows:

The Arbitrator incorporates by reference the above Findings of Fact herein. Petitioner was employed by Respondent as a machine operator from February 2009 to July 2015. In this production position, Petitioner was required to grind, deburr, clean and otherwise handle and manipulate parts in highly repetitive manner involving frequent bending, twisting, gripping, and pinching of both wrists and hands. Petitioner was also required to use air tools, grinders, sanders, wire wheels and other highly vibratory hand tools throughout each work day. Petitioner's testimony and medical records demonstrate his bilateral carpal tunnel symptoms developed slowly during the last few years of his employment with Respondent. Petitioner's Section 12 examiner, Dr. Eilers, opined Petitioner's carpal tunnel syndrome followed an appropriate history and progression of his symptoms and was a result of his repetitive work activities with Respondent. Conversely, while Respondent's Section 12 examiner, Dr. Vender, agreed Petitioner's history of complaints and medical history were consistent with

bilateral carpal tunnel syndrome, he opined "The video demonstrates normal use of the hands and upper extremities. There are no significant repetitive activities. There is only very limited exposure to forces. These activities would not be contributory to the development of carpal tunnel syndrome." He did concede in his deposition that if the video presented was an inaccurate demonstration of Petitioner's employment, he may reconsider his causal connection opinions.

The Arbitrator finds Dr. Vender's opinion vague and unconvincing. In his deposition, Dr. Vender testified that his understanding of Petitioner's job description and his opinions as to causation, were heavily reliant on the truth and accuracy of the job description and video provided to him by Respondent. Dr. Vender did not verify the job description with Petitioner. In addition to Petitioner, Mr. Kenneth Katrein, and Mr. Kevin Videgar all testified as to the inaccuracy of Respondent's video, which showed incomplete set-ups, a slower pace of work, and did not demonstrate all of Petitioner's job duties. Their testimony was hardly disputed by Respondent's witnesses, Mr. Dale Schubert and Mr. Keith Johnson. Instead, Mr. Schubert and Mr. Johnson largely agreed with Petitioner and the other witnesses' description of Petitioner's job duties. Furthermore, Dr. Vender offers no alternative possibility as to the cause of Petitioner's bilateral carpal tunnel.

Petitioner testified that he orally reported having tingling and soreness throughout both arms from wrist to shoulder to Mr. Stan Dale, Respondent's previous general manager, in early 2015. He attempted to treat his pain by taking 800mg of ibuprofen twice daily. In April of 2015, Petitioner was moved to the Ukoma lathe machine, but his use of vibratory tools and arm pain did not change. On June 12, 2015, Petitioner again reported his problems to Respondent by submitting a written report. Petitioner then sought treatment with Dr. Bhurgri at OSF St. Elizabeth Hospital on June 15, 2015. Mr. Johnson testified he took over as president on June 1, 2015, after Stan Dale retired, and did not find an injury report in Stan's records. Mr. Johnson indicated he knew nothing about Petitioner's conversations with Stan Dale. Petitioner filed the instant case with the Commission (IWCC) on July 9, 2015, with a notice date of July 14, 2015.

An employee seeking benefits for gradual injury due to repetitive trauma must meet the same standard of proof as a petitioner alleging a single, definable accident. *Nunn v. The Industrial Comm'n,* 157 Ill.App.3d 470, 510 N.E.2d 502 (4th Dist. 1987). The petitioner must prove a precise, identifiable date when the accidental injury manifested itself. "Manifested itself" means the date on which both the fact of the injury and the causal relationship of the injury to the petitioner's employment would have become plainly apparent to a reasonable person. *Peoria County Belwood Nursing Home v. The Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). The test of when an injury manifests itself is an objective one, determined from the facts and circumstances of each case. *Luttrell v. The Industrial Comm'n*, 154 Ill.App.3d 943, 507 N.E.2d 533 (2nd Dist., 1987).

Based on all the above, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of employment with Respondent on June 12, 2015. The Arbitrator further finds that Petitioner's bilateral carpal tunnel syndrome is causally related to his employment with Respondent and that Respondent was provided notice of accident on June 12, 2015, the date Petitioner reported his bilateral carpal tunnel syndrome symptoms to Respondent via Stan Dale, general manager at that time.

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:

The Arbitrator incorporates by reference the above Findings of Fact herein. Dr. Eilers opined that Petitioner's treatment has been reasonable, appropriate, and necessary to treat bilateral carpal tunnel syndrome. Respondent has failed to present any evidence or testimony to dispute either the reasonableness or necessity of

Petitioner's medical treatment. Accordingly, the Arbitrator finds the medical services that were provided to Petitioner were reasonable and necessary.

The Arbitrator further finds that Respondent has not paid all appropriate charges for medical services. As reflected in Petitioner's Exhibit 1, there are gross bills of $25,451.90 (OSF Medical Group: $4,919.00; OSF St. Elizabeth Medical Center: $19,055.90; Central Illinois Radiological Associates: $53.00; Dr. Garg: $1,424.00). Of this amount, Petitioner's personal insurance paid $20,246.99, Petitioner paid $101.21 out of pocket, and $1,904.86 remains outstanding (OSF Medical Group: $435.76; OSF St. Elizabeth Medical Center: $975.56; Dr. Garg: $493.54). Pursuant to the fee schedule, Respondent shall reimburse Petitioner's out-of-pocket expenses, pay all outstanding medical expenses, and hold Petitioner harmless from any repayment obligations of his personal insurance for bills it paid relative to this matter.

With respect to L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (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. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall 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.

(b) Also, the Commission shall base its determination on the following factors:

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a machine operator at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes, however, that Petitioner

has not returned to work for Respondent and Dr. Eilers opined that Petitioner may have some limitations with left hand grip strength should he attempt to return to similar repetitive work. Because of this uncertainty, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 57 years old at the time of the accident. Because of Petitioner's advanced age he will live with his permanent disability for a shorter period than an younger individual, 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 that no evidence or testimony was presented as to Petitioner's future earnings capacity. 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 Petitioner had successful bilateral carpal tunnel releases with mild residual hand grip strength weakness. Although Dr. Eilers provided that he would not recommend Petitioner returning to repetitive tasks, he felt Petitioner could return to similar work activities, albeit with some limitations due to Petitioner's left hand weakness. The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of his left hand (28.5 weeks) and a 12-1/2% loss of his right hand (23.75 weeks), pursuant to §8(e)9 of the Act.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRYAN RASMUSSEN,

Petitioner,

vs.

NO: 15 WC 16860
16 WC 19515

JEWEL-OSCO,

Respondent.

ORDER

This matter comes before the Commission pursuant to a Motion for Fees filed by Dworkin & Maciariello, the former attorney of record for the Petitioner, Bryan Rasmussen. Petitioner's current attorney of record is Linn, Campe and Rizzo.

The motion was presented and heard before Commissioner Michael J. Brennan on May 17, 2018 in Chicago, Illinois. After receiving the record and examining the testimony, exhibits, and pleadings, the Commission finds that Dworkin & Maciariello is entitled to $1,720.00 in Attorneys' Fees under Section 16(a), for the reasons set forth below:

1. On May 7, 2015, the Petitioner retained Dworkin & Maciariello to represent him for injuries sustained on January 5, 2015. PX.1.

2. On May 22, 2015, Dworkin & Maciariello filed an Application for Adjustment of Claim at the Illinois Workers' Compensation Commission. A case number of 15 WC 16860 was assigned to the claim. According to the Application, the Petitioner sustained a right shoulder injury while at work on January 5, 2015.

3. Between January 14, 2016 and February 8, 2016, attorney Adrian Cherikos, attorney for Dworkin & Maciariello, and Tracy Friedman, claims examiner for Sedgwick Claims Management Services, negotiated a settlement of $17,718.75, representing 12.25% loss of use of the man-as-a-whole. PX.1.

4. On March 16, 2016, Petitioner hired John Rizzo of Linn, Campe and Rizzo. T.38. An Application for Adjustment of Claim was subsequently filed for the January 5, 2015 injury. The claim was assigned a case number of 16 WC 19515.

5. No attorney representation agreement or substitution of attorney was offered into evidence establishing that the firm of Linn, Campe and Rizzo was retained to represent the Petitioner on case 15 WC 16860.

6. On May 3, 2016, Adrian Cherikos alleges that he spent 1.3 hours drafting a settlement contract for submission to Tracy Friedman of Sedgwick. PX A.

7. On May 4, 2016, Tracy Friedman signed, dated and submitted the settlement contract to Petitioner's attorney, Adrian Cherikos. Comm. Ex.1.

8. On May 4, 2016, attorney Adrian Cherikos sent a letter to Petitioner enclosing the proposed settlement contract for his signature. PX. D.

9. On March 17, 2017, Arbitrator Stephen Friedman approved a settlement contract in the amount of $17,875.00, representing 12.5% loss of use of the man-as-a-whole. John Rizzo, of Linn, Campe and Rizzo, was listed as the Petitioner's attorney on the settlement contract. The settlement contract was for cases 15 WC 16860 and 16 WC 19515. PX.1. Mr. Rizzo stated on the record that the approved settlement contact was drafted by Respondent's attorney. T.32.

10. On January 16, 2018, Dworkin & Maciariello filed its Petition for Attorneys' Fees. Per its *Quantum Meruit* Petition, Dworkin & Maciariello allege that they spent 11 hours on Petitioner's case at an hourly rate of $300.00. They request fees totaling $3,300.00. Commission Exhibit 1.

Section 16 of the Act grants the Commission, "the power to determine the reasonableness and fix the amount of any fee of compensation charged by any person, including attorneys for any service performed in connection with [the] Act, or for which payment is to be made under [the] Act or rendered in securing any right under [the] Act." The Act also expressly directs the Commission to hear and determine disputes involving the division of attorney's fees where the claimant has been represented by more than one attorney. 820 ILCS 305/16a(J); see also 50 Ill. Adm. Code §9080.10(b).

The Commission notes that Dworkin & Maciariello was hired by Petitioner on May 7, 2015. The Petitioner then hired Linn, Campe and Rizzo on March 16, 2016 for the same accident. No substitution of attorney form was filed with the Commission, relative to case # 15 WC 16860. Instead, Linn, Campe and Rizzo filed a separate claim generating a second claim number for the same accident. Linn, Campe and Rizzo settled both claim numbers, despite not being listed as the attorney of record for 15 WC 16860.

The Commission finds that through Petitioner's actions, he discharged Dworkin & Maciariello on March 16, 2016 when he hired Linn, Campe and Rizzo. The Commission finds that Petitioner retained Linn, Campe and Rizzo on March 16, 2016, based upon Mr. Rizzo's representation that this is the day that Petitioner appeared at his office and signed documents that led to the filing of Claim # 16 WC 19515.

However, it does not appear that either Petitioner or Linn, Campe and Rizzo, ever communicated his dismissal of Dworkin & Maciariello at that time. Effectively, it should

have become obvious to Dworkin & Maciariello that Petitioner was no longer involved with them by July 23, 2016.

A discharged attorney is not entitled to recover the full amount of contractually agreed-upon fees, but is instead entitled to reimbursement on a *quantum meruit* basis for the legal services which he has actually performed on his former client's behalf. *Simon v. Auler*, (1987) 108 Ill. Dec. 525, 508 N.E.2d 1102 citing *Rhoades v. Norfolk & Western Ry. Co.* (1979), 78 Ill. 2d 217, 35 Ill. Dec. 680, 399 N.E.2d 969. When Petitioner discharged the Plaintiff's firm, which was working under a contingent fee contract, the contract ceased to exist and the contingency terms of the contract were no longer considered operative. *Wegner v. Arnold*, (1999), 305 Ill. App. 3d 689, 713 N.E.2d 247, 238 Ill. Dec. 1001. The *Wegner* court specifically held that "A discharged attorney is entitled to be paid on a *quantum meruit* basis a reasonable fee for services rendered before discharge." *Id.* When an attorney claims fees based on *quantum meruit* and the right to recovery is established, the court should literally award the attorney as much as she deserves. *Anderson v. Anchor Organization for Health Maintenance*, 274 Ill. App. 3d 1001, 1007, 654 N.E.2d 675, 211 Ill. Dec. 213 (1995).

The court in *Wegner* set forth several factors to be used in making a *quantum meruit* determination. These factors include: 1) the time and labor required, 2) the attorney's skill and training, 3) the nature of the cause, 4) the novelty and difficulty of the subject matter, 5) the attorney's degree of responsibility in managing the case, 6) the usual and customary charge for that type of work in the community, and 7) the benefits resulting to the client. See also *Simon v. Auler*, (1987) 108 Ill. Dec. 525, 527. The Commission's decision in the instant matter is based on its consideration of each of these factors.

Dworkin & Maciariello presented evidence relevant to a *quantum meruit* analysis. The Commission notes that Dworkin & Maciariello alleged that they expended 11 hours representing the Petitioner. The itemized Petition reveals that they conducted multiple telephone conferences with the Petitioner; they filed an Application for Adjustment of Claim at the Commission; they entered into settlement negotiations with the insurance company; they obtained a settlement offer of $17,718.75; and, they attempted to advise Petitioner of the settlement offer. By this time however he had retained the firm of Linn, Campe and Rizzo to represent him.

The Commission notes that not all the work noted in Dworkin & Maciariello's analysis was completed by the time Petitioner terminated his relationship with Dworkin & Maciariello. The Commission further notes that there is sufficient evidence establishing that Dworkin & Maciariello conveyed the settlement offer to the Petitioner. But, again, this was tendered after Petitioner signed on with Linn, Campe and Rizzo.

The evidence establishes that Linn, Campe and Rizzo settled the matter for $17,875.00, or $156.25 more than what Dworkin & Maciariello proposed. Linn, Campe and Rizzo did not draft the settlement contract. Respondent's attorney, Wiedner & McAuliffe, drafted the version of the contract that was approved. Linn, Campe and Rizzo

offered no *quantum meruit* evidence as to the value of the services they provided to the Petitioner.

The Commission finds that Dworkin & Maciariello has proven that its services resulted in benefit to the Petitioner under the *quantum meruit* analysis. The Commission, however, does not accept either the number of hours claimed, or the hourly rate claimed by Dworkin & Maciariello.

From its perspective, the Commission believes the claimed hourly rate of $300.00 per hour is excessive and should be reduced. The Commission believes that an hourly rate of compensation at $200.00 per hour would be appropriate for the type of work performed on Petitioner's behalf by Dworkin & Maciariello.

Though Dworkin and Maciariello allege an appropriate rate of compensation to be $300.00 per hour, they provide no justification for remuneration at that level. The record fails to demonstrate the expertise of the attorney handling the claim. Further, the record fails to indicate the level of sophistication needed by an attorney to bring the claim forward towards resolution.

Minus this information, the Commission believes the claimed rate of compensation at $300.00 per hour is excessive. Based upon the Commission's collective experience, the Commission believes that a lower hourly rate of compensation is apparent. It is for this reason that the Commission believes a compensation rate of $200.00 per hour will appropriately compensate Dworkin & Maciariello for their services to Petitioner.

The Commission also finds that the 11 hours of work claimed by Dworkin & Maciariello is not reasonable. Petitioner terminated his relationship with Dworkin & Maciariello on March 16, 2016, but he failed to send a written notice of termination to them. Additionally, Linn, Campe and Rizzo were equally delinquent in notifying Dworkin & Maciariello of Petitioner's termination. It is for this reason that the Commission believes it appropriate to award fees to Dworkin & Maciariello through July 23, 2016.

Based upon the above, the Commission finds that Dworkin & Maciariello is entitled to receive fees at a rate of $200.00 per hour, for a period of 8.6 hours, with a cash value of $1,720.00 for services rendered to Bryan Rasmussen.

The Commission awards Dworkin & Maciariello $1,720.00 of the total $3,575.00 in fees, and awards Linn, Campe and Rizzo the remaining $1,855.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that Dworkin & Maciariello is entitled to $1,720.00 in attorneys' fees under Section 16(a) of the Act and Linn, Campe and Rizzo is entitled to the remaining $1,855.00.

DATED: SEP 19 2018

MJB/tdm
D: 9/13/18
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

☐ 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

PEARL MAC LACHLAN,

Petitioner,

vs.

NO: 15 WC 2577

CONSOLIDATED SCHOOL DIST. #158,

Respondent.

18IWCC0568

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, notice, causal connection, medical expenses, temporary total disability (TTD), permanent partial disability (PPD), and any other issues presented by the transcript, 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. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

The Commission affirms the Arbitrator's findings that Petitioner sustained a work-related accident on October 28, 2014, and that Petitioner provided proper notice to Respondent in accordance with the Act. Petitioner, a 73-year-old bus assistant for special needs students, alleged injury to her left shoulder, left wrist, and left knee on October 28, 2014, when she tripped on

wheelchair straps inside the bus. (T.10-12). Petitioner testified that she fell on the left side of her body, and added, "I was trying to reach with my left hand to get a seat, but I couldn't reach them. It was too quick. I just fell." (T.12-13).

The Commission further affirms the Arbitrator's finding that Petitioner's left knee condition was causally related to the accident. However, the Commission finds no causal connection between the October 28, 2014 accident and Petitioner's current condition of ill-being as it relates to her left shoulder and left wrist; the Commission, therefore, reverses the Arbitrator's Decision in this regard.

The Commission notes that Petitioner reported to the Centegra Occupational Medicine facility on the date of accident, October 28, 2014. Petitioner's complaints on that date, as well as the doctor's examination, x-ray findings, and treatment recommendations only pertained to Petitioner's left knee and left foot. The Centegra record was silent as to Petitioner's left shoulder and left wrist. Petitioner followed-up with Centegra on October 31, 2014 and November 7, 2014; the progress notes were again silent as to any complaints related to the left shoulder and left wrist. (PX1, Deposition Exhibit 2; PX5; RX1).

The Commission further notes that Petitioner had previously injured her left arm on August 9, 2014. Petitioner testified that she had been at her daughter's house and had fallen from a bed. (T.18-19; PX1, Deposition Exhibit 2). Petitioner sought emergency room treatment at Presence St. Mary Hospital. The emergency room record indicated that Petitioner fell while getting into bed, and she injured her left wrist. Petitioner completed an x-ray of the left wrist on August 10, 2014; the impression demonstrated an old healed fracture of the distal left radial metaphysis, but no acute fracture, subluxation, or dislocation. There was mild soft tissue swelling of the left wrist. (PX1, Deposition Exhibit 2). Petitioner followed-up with her primary care physician, Dr. Patricia Merlo, on August 15, 2014; Dr. Merlo's medical record noted the August 2014 accident, and that "pt was at daughters house when she fell forward onto outreached hands." (PX1, Deposition Exhibit 2; PX4; PX7, pgs. 6-7; RX2). Dr. Merlo diagnosed Petitioner with a wrist strain, and prescribed anti-inflammatory medication. She also stated that Petitioner may need an MRI of the wrist to evaluate for an occult fracture. (PX1, Deposition Exhibit 2; PX4; PX7, pgs. 6-7; RX2).

In addition to the prior injury to Petitioner's left arm, and the delayed reporting of complaints to said arm after the October 28, 2014 accident, the Commission also finds that the medical records from Petitioner's main treating physicians, Dr. Merlo, and orthopedic surgeon, Dr. Joshua Alpert, contained considerable inconsistencies.

Dr. Merlo's progress note, dated October 27, 2014 [the day before the work-related accident], indicated that Petitioner was there for a six-month follow-up after lab work; under "Assessments," "pain in limb" was noted. Dr. Merlo further detailed "pt having persist pain in left arm following accid[ent] at work. referred to Midwest Bone and Joint." On page 3 of Dr. Merlo's October 27, 2014 progress note, she added an addendum dated January 14, 2016: "pt called 10-29-14 stating she fell at work 10-28-14 and injured her knee. Although 'Pain in limb' is entered to this 10-27-14 note, this pain did not occur until after her work related accident on 10-28-14." (PX1, Deposition Exhibit 2; PX4; RX2). Dr. Merlo testified at her deposition that she had simply entered Petitioner's complaints of left arm pain on the wrong progress note. (PX7, pg. 13).

The Commission does not find Dr. Merlo's testimony convincing or sufficient to resolve the discrepancy in the medical record. By Dr. Merlo's explanation, she had obtained the information regarding Petitioner's "pain in limb" and left arm complaints from a telephone call she received from Petitioner on October 29, 2014. Dr. Merlo's medical records contained a note specific to the telephone encounter of October 29, 2014; nowhere in that record did it indicate any injury or complaints to the left arm. The note only referenced Petitioner's injury to her knee. (PX1, Deposition Exhibit 2; PX4; RX2). The Commission doubts the integrity of Dr. Merlo's medical records.

Petitioner next treated at Midwest Bone and Joint with Dr. Alpert; her first appointment with Dr. Alpert was on December 8, 2014. (T.17; PX1, pg. 9; PX2). Dr. Alpert's December 8, 2014 office visit note is the first time the left wrist is mentioned in the arbitration record. Dr. Alpert noted that Petitioner had injured her left wrist when she fell onto her outstretched hand; there is no mention of a work accident. His medical records also contained issues relative to dates. Dr. Alpert had reported the injury date as August 9, 2014, and not October 28, 2014. Dr. Alpert's notes from December 8, 2014 through January 21, 2015 indicated that the injury date was August 9, 2014. (PX1, Deposition Exhibit 3; PX2). Dr. Alpert testified at his deposition that this was an error. (PX1, pg. 43). However, during his testimony, Dr. Alpert contradicted himself and stated that Petitioner attributed her current left wrist pain to the August 2014 fall because she could not recall any mechanism of injury for the left wrist other than that fall. Dr. Alpert further appears to rely on the August 2014 date of injury because he ordered an MRI for the left wrist on December 8, 2014, indicating, "it has been 4 months since she fell, she has significant pain, and she cannot lift objects." (PX1, pgs. 15-16; PX1, Deposition Exhibit 3; PX2).

The Commission notes that at the time Dr. Alpert began treating Petitioner, he did not have or did not review any medical records related to the August 2014 accident; thus, the Commission finds that Dr. Alpert relied exclusively on Petitioner's oral history of injury during the appointments. (PX1, pgs. 32-33). In fact, Dr. Alpert confirmed that the first time Petitioner told him about the October 2014 accident was in January 2015. (PX1, pg. 47). Dr. Alpert stated that Petitioner later requested that he amend the medical records. (PX1, pg. 34).

The first time Petitioner's left shoulder complaints appear in the record was during the December 17, 2014 office visit with Dr. Alpert; Dr. Alpert stated that this was the first time Petitioner told him about her left shoulder. Again, the left shoulder complaints is simply attributed to a "fall"; there is no mention of any work accident. (PX1, pg. 16; 19; PX1, Deposition Exhibit 3; PX2).

During cross-examination, when asked about the lack of complaints related to other body parts during Petitioner's first visit on December 8, 2014, Dr. Alpert explained, "She may have told me about other things and I would have said to her I'm only seeing you for the left wrist today. That's all I can see you for." (PX1, pg. 44). Dr. Alpert also explained: "[M]y office policy is we only see one body part at a time so that makes this a little bit more difficult when you talk about multiple body parts. We only see and evaluate one body part at a time." (PX1, pg. 44).

The Commission finds Dr. Alpert's testimony similarly unconvincing and insufficient to

resolve the discrepancies in his medical records. While the Commission takes no issue with Dr. Alpert's policy of treating one body part at a time, the Commission finds concerning that the description of how Petitioner injured her left wrist and left shoulder only states that it occurred during a fall, and the injury date is listed as August 9, 2014. The Commission also finds significant that according to Dr. Alpert, Petitioner herself attributed her left wrist complaints to the August 2014 fall. Dr. Alpert then proceeded to order an MRI of the left wrist based on that August 2014 date, noting on December 8, 2014, that it had been four months since Petitioner fell and she was having significant pain.

The Commission further finds the opinions of Respondent's Section 12 examiner, Dr. Nikhil Verma, more persuasive than the opinions of Dr. Alpert. Dr. Verma noted Petitioner's previous injury to her left arm in August 2014, when she fell "onto an outstretched hand at her daughter's house." (RX4, pgs. 10-11). Dr. Verma opined that the impact from the fall could have caused injury to Petitioner's left wrist and left shoulder. (RX4, pgs. 12-13). Dr. Alpert similarly testified at his deposition that a fall onto an outstretched hand would cause trauma to the shoulder. (PX1, pg. 35; 46).

Dr. Verma stated that he had reviewed Dr. Alpert's medical records and found significant that Petitioner's left wrist and left shoulders complaints were initially related to the August 2014 fall. (RX4, pgs. 15-16). He too noted that the first time Dr. Alpert's medical records attributed Petitioner's left wrist and left shoulder complaints to the October 28, 2014 accident, was in January 2015. (RX4, pg. 16).

Dr. Verma testified that he had reviewed the MRI of the left shoulder, dated January 7, 2015, and noted a small anterior rotator cuff tear with trace subacromial fluid. (PX1, Deposition Exhibit 3; PX2; RX4, pgs. 11-12; RX4, Deposition Exhibit 2). Dr. Verma opined that Petitioner's left shoulder was not related to the October 28, 2014 accident. The basis for Dr. Verma's opinion was Petitioner's "[p]rior history of trauma, the absence of any acute finding with regard to the shoulder, including complaint of shoulder pain, and the fact that at 74 many patients have rotator cuff tears in the absence of trauma." (RX4, pg. 20). Dr. Alpert had agreed during his deposition that the onset of left shoulder symptoms could be attributed to wear and tear over time. (PX1, pg. 51). Dr. Verma also noted that the delay in reporting the left shoulder complaints was inconsistent with an acute or traumatic rotator cuff tear. (RX4, pg. 20).

Respondent had also sent Petitioner to orthopedic surgeon, Dr. Mark Cohen, for a Section 12 examination of her left wrist; he evaluated Petitioner on November 11, 2015. Dr. Cohen testified that Petitioner had reported to him an injury to her left wrist after a fall on October 28, 2014. He was also aware that Petitioner had previously injured her left wrist in another fall in August 2014. Examination of the left wrist was normal with no significant findings. Dr. Cohen stated that at some point Petitioner "suffered what appears to be a nondisplaced fracture of her wrist that, by the time I had seen her, healed fully, with no evidence of clinical sequelae." Dr. Cohen could not causally relate Petitioner's left wrist condition to the October 28, 2014 accident. "I simply don't have any documentation of any wrist injury in and around the date of the trauma. I have no documentation of a wrist injury that occurred in October from subsequent orthopedic notes from December." (RX5).

On the contrary, Dr. Alpert believed that Petitioner's left shoulder rotator cuff tear and left wrist conditions were causally related to the October 28, 2014 accident. (PX1, pg. 26; 29-30). The basis of Dr. Alpert's opinion included Petitioner's history, her physical exam findings, and the fact that she had no pre-existing left shoulder complaints. (PX1, pg. 29). Dr. Alpert stated that Petitioner's fall in August 2014 did not change his opinion relative to causation for the left shoulder because Petitioner had no complaints pertaining to the left shoulder until she had the October 28, 2014 accident. (PX1, pgs. 29-30). As to Petitioner's left wrist, Dr. Alpert opined that the October 28, 2014 fall caused a non-displaced fracture. (PX1, pg. 30). The basis for his opinion was that the MRI completed in mid-December [December 12, 2014] demonstrated "a fracture that occurred more recently within six weeks," and therefore unrelated to any event in August 2014. (PX1, pgs. 15-16; 30-31; PX1, Deposition Exhibit 3; PX2; PX3).

Taking into consideration the record as a whole, the Commission is not persuaded by Dr. Alpert's opinions. The Commission's Decision must be supported by the record and not based on mere speculation or conjecture. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 215 (2003). The Commission finds serious discrepancy as to which accident caused Petitioner's left arm problems. There is no evidence as to whether Petitioner's left wrist healed following the August 2014 injury, and Dr. Alpert's testimony relative to the timeframe of the wrist fracture is perplexing as up until January 2015, after the December 12, 2014 MRI, Dr. Alpert was relating Petitioner's left wrist condition to the August 2014 accident at her daughter's house.

The Commission further finds Dr. Alpert's testimony that Petitioner had no pre-existing left shoulder complaints to be inadequate. According to the record, Petitioner in fact had no left shoulder complaints whatsoever until December 17, 2014, and even then, Dr. Alpert's medical records do not attribute the left shoulder complaints to a work-related injury.

Based on the evidence in its totality and as illustrated above, the Commission finds that Petitioner failed to establish that her left shoulder and left wrist conditions were causally related to the October 28, 2014 work-related accident.

As the Commission does not find that Petitioner's left shoulder and left wrist conditions are causally related to the October 28, 2014 accident, the Commission further finds that Petitioner is not entitled to medical, TTD, or PPD benefits as it relates to the left shoulder and left wrist.

Specifically, the Commission modifies the Arbitrator's award of medical bills to include only those charges related to Petitioner's left knee, and as contained in Petitioner's Exhibit 6. This includes the Centegra medical bills totaling $732.58, and Dr. Alpert's charges for dates of service January 28, 2015 [$323.00] and March 30, 2015 [$218.00].

The Commission further vacates the Arbitrator's award of TTD. Petitioner claims that she is entitled to TTD from December 8, 2015 through August 22, 2016. The Commission notes that Petitioner's alleged time off work was either not supported by the medical records, or was unrelated to Petitioner's left knee condition. In other words, part of the alleged TTD period was due to Petitioner's treatment for her left shoulder and left wrist, which the Commission does not find to be causally related to the October 28, 2014 accident.

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As to PPD, the Commission affirms the Arbitrator's award of 2% loss of use of the left leg, vacates the Arbitrator's award of 12.5% loss of use of the person as a whole for the right shoulder, and further vacates the award of 5% loss of use of the left hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed December 5, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 4.3 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the 2% loss of use of the left leg. The Arbitrator's award of 12.5% loss of use of the person as a whole for the right shoulder, and 5% loss of use of the left hand is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical services as related to the left knee totaling $1,273.58, and as contained in Petitioner's Exhibit 6 as provided in Sections 8(a) and 8.2 of the Act. The Arbitrator's award of medical charges related to the left shoulder and left wrist are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $83,871.47 in medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

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

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

DATED: SEP 19 2018

MJB/pm
O: 08-28-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MacLACHLAN, PEARL
Employee/Petitioner

Case# **15WC002577**

CONSOLIDATED SCHOOL DIST #158
Employer/Respondent

18IWCC0568

On 12/5/2017, 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 1.45% 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:

2333 WOODRUFF JOHNSON & EVANS
DEXTER J EVANS
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2461 NYHAN BAMBRICK KINZIE & LOWRY
MICAELA M CASSIDY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

- [ ] 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
CORRECTED

PEARL MACLACHLAN
Employee/Petitioner

v.

CONSOLIDATED SCHOOL DIST. #158
Employer/Respondent

Case # **15** WC **02577**

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 **Woodstock, Illinois**, on **September 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 28, 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 **$17,511.00**; the average weekly wage was **$336.75**.

On the date of accident, Petitioner was **73** years of age, ***single*** with 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 **$84,393.18** under Section 8(j) of the Act. Respondent shall keep Petitioner safe and harmless from any and all claims or liabilities that may be made against her.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $224.50/week for 37 weeks, commencing December 8, 2015 through August 22, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 77.05 weeks because the injury sustained caused 12.5% loss of use the person as a whole (62.5 weeks), as provided in Section 8(d)2 of the Act; 5% loss of use the left hand (10.25 weeks) and 2% loss of use the left leg (4.3 weeks), as provided in Section 8(e) of the Act.

Respondent shall pay reasonable/necessary medical services pursuant to the medical fee schedule in the amount of $140,226.58 (Balance: $60.00) as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

11/4/17
Date

ICArbDec p. 2

DEC 5 - 2017

18IWCC0568

FINDINGS OF FACT:

It is stipulated that on October 28, 2014, Petitioner, age 73 at the time, suffered a work-related injury while working for Respondent. Petitioner worked as a school bus assistant for special needs children. Her job duties include tying down wheelchairs for the special needs students on the bus. Petitioner testified that on the day of her work accident, she went to push a red button on the back of the bus and tripped over a wheelchair strap, landing onto her left side. Petitioner stated that she initially felt dazed, but then noticed pain all over her body. At that time, the most significant pain was in her left knee. Petitioner stated the bus driver assisted in getting her up. She proceeded to her supervisor, Laura Hooper, to report the incident and was sent to Centegra.

Petitioner went to Centegra Occupational Health that day. (Pet. Ex. 5) Although she recalls telling Centegra that her body hurt all over, the main focus that day was for her left knee and ankle. The history noted was that she fell off of the tie downs and injured both knees. An x-ray of Petitioner's left knee was negative and she was diagnosed with a left knee contusion. She was provided with a sleeve for her knee and taken off work until October 30, 2014. (Pet. Ex. 5) Petitioner stated she went home after the appointment. She was in a lot of pain and had trouble sleeping that night.

The following day, on October 29, 2014, Petitioner called her primary care physician, Dr. Patricia Merlo. She reported falling the previous day and suffering injuries to her left knee and left upper extremity. (Pet. Ex. 4, Pet. Ex. 7, pp.13, 19-20) Petitioner had seen Dr. Merlo on the day before her injury, October 27, 2014, for her 6-month labs. (Pet. Ex. 4). In the note from that encounter, it was indicated that Petitioner had "persistent pain in left arm following an accident at work" and that she was being referred to Midwest Bone and Joint Institute. The note was electronically signed on November 3, 2014, several days after the original appointment and also after Petitioner had called Dr. Merlo to report the work injury. Dr. Merlo wrote an addendum to her October 27th note. This was to clarify that reference to Petitioner's work injury and pain in her left upper extremity in that the note was actually taken from a telephone encounter the day after the October 28, 2014 work injury. (Pet. Ex. 4; Pet. Ex. 7, Merlo Ex. 1)

On October 31, 2014, Petitioner returned to Centegra Occupational Health. She was released to return to work with regard to her left knee contusion and left ankle sprain. She was advised to alternate ice and heat for bruising to the left knee. Petitioner returned to Centegra on November 7, 2014 with complaints of intractable pain in the left knee. Centegra referred Petitioner to "orthopedics". (Pet. Ex. 5, Resp. Ex 1)

On December 8, 2014, Petitioner was seen by Dr. Joshua Alpert of Midwest Bone & Joint Institute in regard to her left wrist. At her first appointment with Dr. Alpert, Petitioner reported having had a prior fall onto her left hand on August 9, 2014. (Pet. Ex. 2) Petitioner testified that this happened as she was carrying linens and fell. Petitioner complained only of left wrist pain at the time and testified that she did not injure her left shoulder during the incident. The records reflect that Petitioner was seen at Presence St. Mary's Hospital the following day on August 10, 2014 at which time an x-ray was taken that was negative. (Resp. Ex. 3) She was diagnosed with a left wrist contusion/sprain and given a splint. (Resp. Ex. 3). She made no complaints in regard to her left shoulder. She was seen one final time for follow up with Dr. Merlo on August 15, 2014 and reported that her wrist was feeling better. (Pet. Ex. 4) Petitioner testified that she sought no further treatment following the August 9th fall. Petitioner stated that from August 16, 2014 up until her work injury on October 28, 2014, she worked her regular job duties as a school bus assistant. She reported that she felt fine over those two (2) months and had no further problems with her left wrist.

At the December 8, 2014 appointment, Dr. Alpert ordered X-rays of the left wrist and diagnosed left wrist sprain and possible nondisplaced fracture. The doctor provided her with a carpal tunnel wrist splint for comfort. Dr. Alpert also recommended a left wrist MRI noting that four (4) months had passed since her fall, and she still had significant pain and trouble lifting objects. (Pet. Ex. 2) The MRI when performed revealed a non-displaced fracture of the distal radius.

Petitioner was next seen by Dr. Alpert on December 17, 2014. In addition to left wrist complaints, Dr. Alpert noted Petitioner also reported significant left shoulder pain that also may have occurred from the fall. (Pet. Ex. 2) Petitioner testified that the fall she was referring to was the work-related fall of October 28, 2014. Dr. Alpert testified that the reason why the injury date field still said "8/9/14" (the date of the fall at her daughter's house) was because the computer system just repopulates the injury date from the note before. (Pet. Ex. 1, p.43) Due to the fracture, Dr. Alpert placed Petitioner's wrist in a short arm cast. In regard to her shoulder, Dr. Alpert recommended a new evaluation and possible MRI. (Pet. Ex. 2) Dr. Alpert testified that Petitioner may have made complaints about her left shoulder at her initial appointment, but that he only sees patients for one body part at a time. (Pet. Ex. 1, p.44) Petitioner testified that her focus was on whichever body part was giving her the most problems at the time. On the day of the accident, it was her knee. Then it was her wrist. Once the other two were under control, Petitioner's focus was the pain she had in her left shoulder.

Petitioner's left shoulder was examined by Dr. Alpert on December 24, 2014. Dr. Alpert noted Petitioner reported that the pain in her shoulder began 1 month ago and that she could not recall an injury other than the fall which caused her distal radius fracture. She had no formal treatment to the shoulder thus far. She reported that reaching across her body and overhead caused pain in her upper arm. She also reported being unable to sleep on her left shoulder. A physical examination revealed that Petitioner had pain and weakness in her left shoulder and experienced pain during range of motion testing. Dr. Alpert diagnosed a possible rotator cuff tear. Due to the significant pain and weakness he also prescribed an MRI. (Pet. Ex. 2) Petitioner testified that the fall she was referring to was the fall of October 28, 2014 on the school bus. As for why she said 1 month ago, Petitioner testified that was an estimate.

Petitioner returned to Dr. Alpert on January 12, 2015 regarding the left shoulder. The doctor's record show "[s]he had a work-related injury that occurred in October where she broke her left wrist and injured her left shoulder." The doctor also noted Petitioner had been complaining of significant knee pain and swelling. Dr. Alpert further noted the prescribed MRI had been completed and demonstrated a small full-thickness rotator cuff tear. Dr. Alpert assessed "73-year old female with a left shoulder work-related injury on October of 2014 consistent with a small full thickness rotator cuff tear." Dr. Alpert recommended conservative treatment which included physical therapy and a cortisone injection. The doctor also noted x-rays were taken of the left wrist which did not show any evidence of significant displacement or pathology. (Pet. Ex. 2)

On January 21, 2015, Petitioner returned to Dr. Alpert and received a cortisone injection to the left shoulder. Dr. Alpert referred her for physical therapy to the left shoulder and wrist. He also noted that he was going to see Petitioner in a week regarding the left knee. (Pet. Ex. 2)

On January 28, 2015, Petitioner saw Dr. Alpert for follow up on her left knee. Her physical examination was normal and Dr. Alpert diagnosed Petitioner with exacerbation of her preexisting arthritis. The office note from that date contained a typographical error which said Petitioner also had "non work-related" injuries to her left shoulder and left wrist. Dr. Alpert clarified the error in both a subsequent note (on August 24, 2015) as well as at his deposition. (Pet. Ex. 1, pp.25, 50, 57; Pet. Ex. 2) Petitioner saw Dr. Alpert again on March 30, 2015 in which she reported her main complaint to be with respect to her left shoulder. Dr. Alpert recommended that she continue with physical therapy. Dr. Alpert also noted that if therapy and the injection did not alleviate Petitioner's symptoms, she would be a candidate for a left shoulder arthroscopy, subacromial decompression,

and rotator cuff repair with AC joint resection. Dr. Alpert administered another cortisone injection into Petitioner's left shoulder on May 11, 2015. (Pet. Ex. 2)

At her August 25, 2015 appointment with Dr. Alpert, Petitioner reported that she continued to have significant pain in her left shoulder. She noted that any pain that had been alleviated by the cortisone injection had completely come back. A physical exam revealed a significant amount of weakness in Petitioner's left shoulder. Dr. Alpert determined that Petitioner had failed conservative treatment which had included use of anti-inflammatories, cortisone injections, and physical therapy. He recommended surgery. (Pet. Ex. 2) Petitioner had pre-op testing at Sherman Hospital on November 30, 2015 and surgery on December 8, 2015. The post-operative diagnosis was left shoulder rotator cuff tear, left shoulder osteoarthritis, left shoulder Type 2 superior labral tear, and left shoulder subacromial bursitis of the hooked acromion. Dr. Alpert performed a left shoulder arthroscopic rotator cuff repair, subacromial decompression with acromioplasty, distal clavicle resection, biceps tenotomy with extensive debridement of the superior labrum, and open subpectoral biceps tenodesis. (Pet. Ex. 3) Following surgery, Petitioner's arm was placed in a sling. Petitioner was off work following surgery.

Petitioner had post-operative complications. She suffered a left lower extremity deep vein thrombosis which culminated in bilateral pulmonary emboli. This required a hospitalization at Sherman Hospital from December 10, 2015 through December 16, 2015. (Pet. Ex. 3) Petitioner testified that, due to the complications from her surgery, she is required to be on blood thinning medication for the foreseeable future.

Petitioner's first post-operative appointment with Dr. Alpert was on December 21, 2015. At that time, Dr. Alpert wanted to keep her left arm in a sling and started Petitioner on home therapy. On January 25, 2016, Petitioner reported that she still had some weakness with rotator cuff testing. Dr. Alpert ordered therapy to continue with both active and passive range of motion activities. On March 7, 2016, Petitioner reported that she was doing well. At that time, Dr. Alpert increased her therapy to include strengthening activities. (Pet. Ex. 2)

On May 9, 2016, Petitioner reported that she still had a bit of soreness in her left shoulder. However, she no longer exhibited weakness with rotator cuff testing. She did have a positive impingement sign. Dr. Alpert administered a cortisone injection. When Petitioner returned to his office on July 11, 2016, she reported minimal weakness on testing. Petitioner saw Dr. Alpert for the last time on August 22, 2016. She reported that she was much better and had virtually all of her strength back. Dr. Alpert released Petitioner from treatment and returned her to work without restriction. (Pet. Ex. 2)

Petitioner testified that she still has problems with her left shoulder. She has difficulty in doing the following because of pain:

- Vacuuming;
- Holding a hair dryer;
- Reaching overhead more than ¾ of the way;
- Putting a necklace on;
- Scrubbing floors;

With respect to Petitioner's left knee, it is clear from the record that she had prior surgery on said knee. Petitioner testified that, since the work injury aggravated her knee, it locks up occasionally when walking.

Dr. Joshua Alpert – Petitioner's treating orthopaedic surgeon

Dr. Alpert diagnosed Petitioner with a left rotator cuff tear as a result of the work injury. He performed a left shoulder arthroscopy, subacromial decompression, and distal clavicle excision with biceps tendinosis on

Petitioner on December 8, 2015. (Pet. Ex. 1, p.26) Dr. Alpert indicated that Petitioner's fall onto her outstretched hand on the school bus was a mechanism that would have caused the rotator cuff tear. (Pet. Ex. 1, p. 26) Dr. Alpert opined that the October 28, 2014 work accident caused the rotator cuff tear in Petitioner's left shoulder and need for surgery. The basis of his opinion was the history of injury, the physical exam findings, and the fact that Petitioner had no preexisting left shoulder complaints. The doctor stated the fact that Petitioner also had a fall on August 9, 2014 did not change his opinion because there were absolutely no complaints of left shoulder pain following the August 9th fall. Dr. Alpert added the fact that she did not immediately report left shoulder pain was not relevant as that pain was likely masked by the other injuries she had as a result of the work injury, i.e. her left knee and wrist. (Pet. Ex. 1, pp. 29-30)

As for the left wrist, Dr. Alpert opined that the non-displaced fracture was caused by the October 28, 2014 work injury and not the August 9, 2014 fall. His basis for that opinion was that the MRI from December showed a fracture and, since it had been 4 months since the August fall, if Petitioner had suffered a fracture in August, it would have healed by December. Additionally, the MRI showed a fracture which was more consistent with one that occurred more recently, within 6 weeks. As for the left knee, Dr. Alpert diagnosed Petitioner with a contusion and aggravation of preexisting arthritis. (Pet. Ex. 1, pp. 30-31)

Dr. Alpert testified that he made a typographical error in one of his notes in which he referred to the left shoulder, wrist, and knee as "non-work-related." (Pet. Ex. 1, p. 25) As for why the initial medical notes kept referencing the August 9, 2014 fall as the injury date, Dr. Alpert indicated that the date repopulates every visit unless he changes it. (Pet. Ex. 1, p. 43) He mistakenly did not change it until the January 28, 2015 note. (Pet. Ex. 1, p. 47) As for the initial focus on the wrist, Dr. Alpert testified that Petitioner may have mentioned issues with her shoulder at the initial appointment, but he only sees a patient for one body part at a time and the initial visits were for the wrist. (Pet. Ex. 1, p. 44)

Dr. Patricia Merlo – Petitioner's primary care physician

Dr. Merlo saw Petitioner on August 15, 2014 in regard to the left wrist injury she had suffered at her daughter's home on August 9, 2014. (Pet. Ex. 7, pp. 6-7) Her examination of Petitioner's wrist at that time revealed no swelling, no warmth, limited range of motion and black and blue marks. She diagnosed Petitioner with a left wrist sprain and recommended a possible MRI if Petitioner's symptoms did not improve. (Pet. Ex. 7, p. 8) Dr. Merlo confirmed Petitioner had no left shoulder complaints at the August 15th appointment. (Pet. Ex. 7, p. 15) An examination of both the left shoulder and left elbow revealed full range of motion and no treatment to same was recommended. (Pet. Ex. 7, pp. 8-9)

Dr. Merlo saw Petitioner on October 27, 2014 for her 6-month labs. Petitioner underwent no physical examination at that appointment and there was no examination of Petitioner's left upper extremity. Regarding item 6 of the "Assessments" section of the note, there was a notation of persistent pain in the left arm from a work accident with a referral to an orthopedic doctor. (Pet. Ex. 7, pp. 10-11) Dr. Merlo wrote an addendum which clarified that the notation of pain in Petitioner's left arm was not information gleaned from the October 27, 2014 visit. (Pet. Ex. 7, p. 13; also see Addendums attached as exhibits to Dr. Merlo's deposition) The reason for the discrepancy was clarified by Dr. Merlo as follows:

> I saw the patient on October 27th. Later on in the day, the way we record our notes with our electronic medical records is I manually enter all the information from that office visit on my own keyboard. I don't dictate. So I had entered in all the information up to but excluding Number 6, "pain in the limb" when I had finished seeing her, and I hadn't locked the progress note yet until I could go back and review anything.

(Pet Ex. 7, p. 12)

I usually lock the progress note and then it can't be reopened. I usually lock that one or two days later as I wait for all studies to come back as a general statement. However, in that time period, on the 29th, the patient called me saying that she was in a work accident and that she had pain because of it. Unfortunately, I included that diagnosis then with the October 27th note instead of creating something at that time of her phone call.

So the entry from the Number 6, "pain in the limb," did not occur when I was talking to her October 27. I added that one in prior to locking the progress note.

(Pet. Ex. 7, 13)

Dr. Merlo did not electronically sign and lock the note until November 3, 2014. The reason for the second addendum was because she had accidentally put the wrong year of the appointments down in the first addendum. (Pet. Ex. 7, pp. 13-15)

Dr. Nikhil Verma – Respondent's left shoulder and left knee IME

Petitioner was seen by Dr. Verma for an independent medical examination at the request of Respondent on November 11, 2015. The doctor testified that Petitioner gave a verbal history of having sustained a left wrist, left shoulder and left knee injury when she fell on the school bus on October 28, 2014. Dr. Verma reviewed records from Dr. Merlo, Presence St. Mary's Hospital, Centegra Occupational Health Center and Dr. Alpert as part of his evaluation. He testified that Petitioner's history to him was inconsistent with the treating medical records. (Resp. Ex. 4, pp. 7-8) Dr. Verma testified that the mechanism of Petitioner's fall onto her outstretched left arm/hand in August 2014 may have also caused trauma to the left shoulder. (Resp. Ex. 4, pp.12-13) Dr. Verma testified that the records from Centegra on the date of the work injury failed to indicate any trauma to the left upper extremity, and that the only diagnostic testing was to the left knee. Likewise, the record of Petitioner's call to Dr. Merlo on October 29, 2014 mentions only a left knee injury. In addition, the records from Petitioner's first visit to Dr. Alpert on December 8, 2014 fail to mention the work injury on October 28, 2014 or any trauma to the left knee or foot. Those records include a history of a left wrist trauma on August 9, 2014 after a fall onto her outstretched hand. (Resp. Ex. 4, pp. 14-15)

Dr. Verma diagnosed Petitioner with a left shoulder rotator cuff tear and preexisting osteoarthritis. (Resp. Ex. 4, 19:22-24). While Dr. Verma testified that he believed that Petitioner had suffered a left knee contusion as a result of the work injury, he did not find the left shoulder to be related. The main basis for Dr. Verma's opinion was the absence of acute findings, shoulder complaints contemporaneous with the work accident, and the fact that she was 74 years old. (Resp. Ex. 4, p. 20) Due to the left knee diagnosis of "contusion", Dr. Verma assessed a 0% impairment rating. (Resp. Ex. 4, p.22) On cross-examination, Dr. Verma testified that if there was some documentation of pain in Petitioner's left upper extremity within a day of the work accident, it could change his opinion. (Resp. Ex. 4, p. 24) The doctor further indicated that if there was a referral to see an orthopedic surgeon for her left upper extremity in the same time frame, that would be information that could change his opinion. (Resp. Ex. 4, p. 29)

Dr. Mark Cohen – Respondent's left wrist IME

Petitioner was also seen for a second independent medical examination at the request of Respondent with Dr. Cohen on November 11, 2015. This examination was specific to Petitioner's left wrist. Dr. Cohen diagnosed Petitioner with a non-displaced fracture of her left wrist. (Resp. Ex. 5, 9:15-22). During the IME, Petitioner reported to Dr. Cohen that she injured her left wrist as a result of a fall on the school bus on October 28, 2014. (Resp. Ex. 5, pp. 10-11) Dr. Cohen reviewed records from Presence St. Mary's Hospital regarding

Petitioner's left wrist injury on August 9, 2014. He stated there was evidence on X-rays taken in his office on November 11, 2015 that Petitioner sustained a non-displaced fracture to her left wrist in the past, which had healed. (Resp. Ex. 5, p. 9) Dr. Cohen indicated that based on his review of the records, he did not believe any of the records documented a left wrist injury or trauma on October 28, 2014. He felt the records indicate that the work injury involved the left knee and foot. (Resp. Ex. 5, pp.11-12). Dr. Cohen stated that he was at a loss as to how to attribute the left wrist injury to the October 28, 2014 work injury without any documentation of a wrist injury near that date. (Resp. Ex. 5, p.12) Dr. Cohen testified that Petitioner had reached maximum medical improvement with regard to her left wrist, and would see no contraindication to her performing full duties regarding her left wrist. (Resp. Ex. 5, pp. 13, 19)

On cross-examination, Dr. Cohen conceded that following the August 9, 2014 fall at her daughter's home, Petitioner was diagnosed with a contusion at the emergency room and a sprain by Dr. Merlo. Dr. Cohen admitted to not having personally looked at the x-ray of Petitioner's left wrist taken at the ER. (Resp. Ex. 5, pp. 21-22) Dr. Cohen's provided that the "only real evidence that we have that a true fracture occurred here is from a magnetic resonance scan that was taken, I believe, in December [2014]. All we know is there was a fracture to the wrist that occurred before December." He agreed that the work accident in which Petitioner fell onto her outstretched hand was a mechanism which could have caused the wrist fracture. (Resp. Ex. 5, p. 24) He had no opinion as to which fall caused Petitioner's wrist fracture, stating, "I'm not a detective." (Resp. Ex. 5, p. 25) Dr. Cohen stated that his opinions were based on the information that Petitioner complained of left upper extremity pain as a result of a work accident on the day before her actual work accident. He also provided that his opinion could change if the information was actually provided after the October 28th work injury. (Resp. Ex. 5, p. 31)

With respect to F.) Is Petitioner's current conditions of ill-being causally related to the injury, the Arbitrator finds as follows:

Left shoulder

With regard to Petitioner's left shoulder, the Arbitrator finds that Petitioner's current condition of ill-being is related to the October 28, 2014 work accident. Significant to this conclusion is the fact that Petitioner had no injury or treatment to her left shoulder prior to the work accident. While Petitioner had a prior fall onto her left hand on August 9, 2014, there is no evidence that Petitioner sustained any type of injury to her shoulder at that time. On the contrary, all of the evidence reflects that the only injury Petitioner sustained was a wrist contusion/sprain.

While the Arbitrator notes that there were some inconsistencies found in the medical records, these inconsistencies can be attributed to the way in which Dr. Alpert and Dr. Merlo handled imputation of their medical notes. Dr. Merlo credibly testified with specificity as to how there came to be a notation of left upper extremity pain from a work injury in the note from the day before Petitioner's work injury. Dr. Merlo simply had not had a chance to lock the note and added information gleaned from a subsequent telephone call in which Petitioner reported her work injury. Likewise, Dr. Alpert credibly testified that the reason why the date of injury in his treatment notes reflected August 9, 2014 is because the date repopulates unless it is changed by the doctor and he forgot to change it. These discrepancies do not take away from the fact that there was no evidence presented of any prior or subsequent injury to Petitioner's left shoulder.

The Arbitrator also finds Petitioner credible is testifying that the reason she did not immediately report her left shoulder pain until her second visit with Dr. Alpert was because she was initially focused on the pain in her left knee and wrist. Additionally, it should be noted that Dr. Alpert testified that Petitioner may have mentioned her left shoulder at the first visit but that he only treats one body part at a time. At that time, he was

treating Petitioner for her left wrist fracture. Dr. Alpert also testified that it was not uncommon for pain in one body part (i.e. left shoulder) to be masked by more significant pain in another (i.e. left wrist/knee).

The Arbitrator is persuaded by the testimony of Dr. Alpert regarding causation for Petitioner's left shoulder injury and subsequent surgery. First, Dr. Alpert was Petitioner's treating surgeon and based his opinion on a complete understanding of the medical history, mechanism of injury, and physical exam findings. On the contrary, Dr. Verma was not aware that Petitioner had called her primary care physician, Dr. Merlo, on the day after the work injury to report not only injury to her left knee, but also to her left upper extremity. Indeed, this is obvious based on Dr. Verma's IME report in which he indicates "there is no documentation of left arm injury in a temporal fashion to her work related fall." (Resp. Ex. 4, IME report, Page 5 of 6). Additionally, he mentioned that there is a "significant discrepancy in the medical record as to whether this left shoulder pain resulted from the work injury of October 28, 2014 or the prior home injury of August 10, 2014." (Resp. Ex. 4, IME report, Page 5 of 6). However, on cross examination, Dr. Verma conceded that Petitioner made no complaints of left shoulder pain when she was seen at the emergency room following the August 9th fall. Likewise, he acknowledged that Petitioner had no treatment or reports of left shoulder pain prior to the October 28, 2014 work accident. (Resp. Ex. 4, p. 23) He agreed that the only injury Petitioner was diagnosed with following the August 9th fall was a wrist contusion/sprain. (Resp. Ex. 4, p. 23) When asked if his opinion could change if there was some documentation of left upper extremity pain within a day of the October 28, 2014 work accident, Dr. Verma testified that it could. (Resp. Ex. 4, p. 24)

The Arbitrator notes that there is such documentation. Dr. Merlo testified that the notation regarding left upper extremity pain from a work injury was taken from information she received when she spoke with Petitioner on the day after he work injury. Because she had not locked the note on the computer, she simply just added it as another diagnosis. The Arbitrator notes that it is clear that Dr. Verma was under the incorrect impression that Petitioner had complained of left upper extremity pain on the day prior to the accident based on the following exchange on cross-examination:

Q. I guess what I'm getting at is people can certainly have an injury and then not initially report it but then the next day could report it, true?

A. They could, but it is also true that she reported pain the day prior, so that doesn't necessarily equate that it is related to.

Q. Now, if those – if that record was in error, that could certainly change your opinion on that, correct?

A. Look, any information that's different could change an opinion one way or the other, but based on what you are telling me, I can't give you an answer that would change it.

(Resp. Ex. 4, p. 40) The Arbitrator relies on Dr. Alpert's testimony. The Arbitrator is not persuaded by the opinion of Dr. Verma as it is clear Dr. Verma's opinions were based on incomplete medical information and history.

The Arbitrator also notes that Petitioner suffered post-operative complications of left lower extremity deep vein thrombosis and bilateral pulmonary embolism which required an extended hospital stay. The Arbitrator finds this causally related to the work accident as a natural sequela of the left shoulder surgery. There was no evidence presented that Petitioner had a deep vein thrombosis or pulmonary embolism which pre-dated the left shoulder surgery.

Left wrist

The Arbitrator finds that a causal relationship exists between Petitioner's current left wrist condition of ill-being and the accident sustained on October 28, 2014. While it is true Petitioner had a prior fall on August 9, 2014 in which she injured her left wrist, she was merely diagnosed with a contusion and sprain. Although Dr. Merlo mentioned that an MRI could be considered if Petitioner's symptoms did not improve, it is clear her symptoms did improve as she sought no other treatment and continued to work unabated for Respondent from the middle of August until her work injury at the end of October.

The Arbitrator gives more weight to the testimony of Dr. Alpert on causation than that of Respondent's IME, Dr. Cohen. Dr. Cohen could not opine which fall caused the wrist injury. Additionally, like Dr. Verma, he was not aware of the discrepancy with Dr. Merlo's notes. As such, he was basing any opinions on an incomplete picture. On the other hand, Dr. Alpert gave a credible opinion as to why he believed Petitioner suffered the wrist fracture as a result of the October 28, 2014 work accident as opposed to the August 9th fall at home. First, Petitioner did not need additional treatment after the August 15, 2014 follow up with Dr. Merlo. More importantly, Dr. Alpert noted that the December 2014 MRI revealed a current fracture of Petitioner's left wrist. He testified that had the fracture occurred in August, it would have more likely than not have been healed at the time of the December MRI.

Left knee

The Arbitrator finds Petitioner's current left knee condition of ill-being is causally related to the work injury. This is supported by the medical records from the date of her injury as well as the testimony of Dr. Alpert and Respondent's IME, Dr. Verma. Dr. Verma diagnosed Petitioner with a left knee contusion. Dr. Alpert diagnosed her with a contusion and aggravation of her preexisting arthritis.

With respect to J.) whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent paid all appropriate reasonable and necessary medical costs, the Arbitrator finds as follows:

The Arbitrator adopts his findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them by reference herein.

Petitioner's Exhibit No. 6 reflects medical charges in the amount of $140,226.58 which were necessitated as a result of the work accident. Having already found for Petitioner on the issue of causation, the Arbitrator finds that all medical services provided to Petitioner were reasonable and necessary and further orders Respondent to pay the fee schedule amount of those bills. The Arbitrator also finds that Respondent has already paid $84,393.18 towards medical. The Arbitrator notes that Petitioner's Exhibit No. 6 reflects a balance of $60.00 in outstanding medical bills to be paid pursuant to the fee schedule.

With respect to K.) what temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

The Arbitrator adopts his findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them by reference herein.

Following surgery, Dr. Alpert had Petitioner off work until he fully released her on August 22, 2016. Having already found for Petitioner on the issue of causation, the Arbitrator orders that Respondent pay Petitioner temporary total disability benefits for 37 weeks which encompasses the day of surgery (December 8, 2015) until the day she was released back to work (August 22, 2016).

With regard to L.) what is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (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. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall 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.

(b) Also, the Commission shall base its determination on the following factors:

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

With regard to subsection (i) of §8.1b(b), with regard to the left shoulder and wrist, the Arbitrator notes neither party offered an AMA impairment rating by any physician. The Arbitrator therefore gives no weight to this factor. With regard to the left knee, Respondent's IME Dr. Verma gave a 0% impairment rating. The Arbitrator gives significant weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner worked with special needs children on a school bus. Most of her work deals with moving/lifting wheelchairs and tying them down. Ultimately, she was released to full duty for all her claimed conditions of ill-being. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 73 years old at the time of her accident. Because Petitioner is in the seventh decade of her life, she will live with his disability for a much shorter period than an younger individual. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner testified that she continues to work for Respondent in her same capacity. It does not appear that her injury affected her earning capacity. As such, 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 last treatment notes from August 22, 2016 show Petitioner had full passive and

active range of motion. The doctor noted she had excellent strength testing and she was neurologically intact. Petitioner testified she continues to experience pain on a regular basis resulting from her left shoulder injury. Petitioner discussed the limitations she has because of pain while performing household chores and personal grooming. Additionally, Petitioner suffered post-operative complications of deep vein thrombosis with pulmonary embolism. As a result, she is required to take blood-thinning medication for the foreseeable future. Significant weight is placed on this factor. With regard to her left wrist, the medical records reflect that Petitioner suffered a fracture of her wrist and when last examined by Dr. Alpert for her wrist, she was still having some pain. When examined by Dr. Cohen for a Section 12 examination, Petitioner reported occasional aching about her left wrist. According to Dr. Cohen, her examination of the left wrist and hand were essentially within normal limits. Significant weight is placed on this factor. With respect to the left knee, Petitioner testified that her knee will lock up on occasion while walking. However, the Arbitrator notes that Petitioner has also had prior surgery and preexisting arthritis in her knee. Based on the above, lesser weight is placed on this factor.

With respect to the left shoulder (and deep vein thrombosis/pulmonary embolism), the Arbitrator concludes Petitioner sustained a 12.5% loss of use of the person. With regard to the left wrist, the Arbitrator concludes Petitioner sustained a 5% loss of us of the left hand. Finally, for the left knee, the Arbitrator finds that Petitioner sustained a 2% loss of use of the left leg.

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

Rosauro Sanchez,
Petitioner,

vs.

NO: 11WC 10206

Illinois State Police,
Respondent.

18IWCC0569

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 March 14, 2018, 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: SEP 19 2018

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LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SANCHEZ, ROSAURO
Employee/Petitioner

Case# **11WC010206**

ILLINOIS STATE POLICE
Employer/Respondent

18IWCC0569

On 3/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% 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 ST
PEORIA, IL 61603

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

6140 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
500 S SECOND ST
SPRINGFIELD, IL 62706

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

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

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

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

MAR 14 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Rosauro Sanchez
Employee/Petitioner

v.

Illinois State Police
Employer/Respondent

Case # 11 WC 10206

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **February 16, 2018.** By stipulation, the parties agree:

On the date of accident, **November 29, 2010**, 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 **$98,316.00**, and the average weekly wage was **$1,890.69**.

At the time of injury, Petitioner was **44** years of age, ***married,*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$669.64**/week for a further period of **112.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **22.5% loss of use of the person-as-a-whole.**

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

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

Signature of Arbitrator

3/12/18
Date

MAR 14 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rosauro Sanchez
Employee/Petitioner

Case # 11 WC 10206

v.

Consolidated cases: N/A

Illinois State Police
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he was employed at the Illinois State Police as a patrol officer when he was injured. He testified that he sustained accidental injuries at work on November 29, 2010 when he attempted to lift his duty bag out of his squad car.

Petitioner testified that he had a back surgery prior to the accident at issue. He testified that he underwent back surgery at L4-L5 on March 9, 2011, and that this was the same area of his prior surgery. He testified that he then participated in physical therapy. He testified that his surgery and physical therapy were, in part, to help his left drop foot. He testified that he now wears an ankle/foot brace because he is unable to lift his foot with "subsequent strength" and that without the brace, he has to lift his foot higher than normal to walk.

Petitioner testified that his back is sore and "...painful most every day." He testified that the Illinois State Police requires a yearly physical fitness inventory test to continue to work as a full-fledged police officer and that he is able to pass the test. He testified that he takes Naproxen and a muscle relaxer on occasion.

On cross examination, Petitioner testified that after his 2002 back surgery, he was able to return to work as a motorcycle police officer. He testified that after his 2002 back surgery and prior to this date of incident on November 29, 2010, his back would hurt bad enough that he would seek medical attention for it. Petitioner acknowledged that he presented to OSF St. Mary's in October of 2009 with complaints of low back pain. Petitioner testified that prior to this incident, he did not need to wear a brace on his ankle. He testified that he is able to satisfactorily perform his job duties. He also testified that he has had no complaints from any supervisors regarding his job performance since he returned to work.

The medical records of OSF St. Mary Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner underwent a Physical Therapy Initial Evaluation on March 18, 2011, at which time it was noted that he stated that he had numbness in his left foot and was unable to move it on his own. It was noted that Petitioner stated that in November of 2010 he was lifting a heavy bag out of his car, that he felt a quick jolt of pain and that his legs gave out. It was noted that Petitioner stated that he went to the doctor and received Naproxen and Flexeril, that he stated that he had some soreness for a few weeks but did not require any other treatment then and that he stated that around the beginning of March, he was standing at church and started to have pain in his leg and that his back started to hurt as well. It was noted that Petitioner stated that on March 9, 2011 he noticed that his

foot was starting to get weak, that the pain was increasing and was so severe that he was unable to stand and could not use his foot at all and that he went to the emergency room and was transferred to OSF St. Francis Medical Center, where he underwent at lumbar L4-5 discectomy that night. It was noted that Petitioner had undergone a previous L4-5 discectomy in 2003. (PX1).

The records of OSF St. Mary Medical Center reflect that Petitioner was seen on April 4, 2011, at which time it was noted that he was seen for a consult for outpatient therapy in Galesburg. The physical therapy Progress Note dated April 13, 2011 noted that the medical diagnoses were that of left foot drop, L4-5 disc herniation status post discectomy and that the treatment diagnosis was that of decreased strength of the left lower extremity, foot and ankle. The onset date was noted to be that of March 9, 2011 and that Petitioner had been seen for therapy three times per week for four weeks. It was noted that Petitioner had met three out of six long-term goals. The physical therapy Progress Note dated May 10, 2011 noted that Petitioner had met three out of four short-term goals and that he stated that his back was feeling better, that he typically had more pain in the morning and that he was stiff. It was noted that Petitioner reported that he felt his ankle was getting stronger, that he stated that when he walked around the house without his brace that he felt more stable and that he was able to control his foot more. (PX1).

The records of OSF St. Mary Medical Center reflect that a Physical Therapy Discharge Summary was issued dated June 15, 2011, which noted that Petitioner had met all of his goals. It was noted that Petitioner stated that he had infrequent episodes of pain, that he stated that he typically had more soreness after doing activities such as washing his car, and that he stated that at most this was 4/10 and that it went away in the expected time. It was noted that Petitioner stated that in the morning he was sometimes stiff or crooked but he did not have any pain and that he stated that he was able to get going pretty quickly as well. It was noted that it was recommended that Petitioner have an orthotics consultation to consider less restrictive AFO as he was able to stabilize medial laterally. (PX1).

The records of OSF St. Mary Medical Center reflect that on August 31, 2012, Petitioner underwent carotid Doppler imaging bilaterally which revealed less than 50% stenosis right and left common and internal carotid arteries. At the time of the March 9, 2011 Emergency Room visit, it was noted that Petitioner stated that his back pain started Sunday, that it was worse on that date, that it radiated down his left leg and that his foot was numb. It was noted that Petitioner stated that he could not lift his foot, that he was sitting at the time and that when he tried to stand he had severe pain. It was noted that in 2002 Petitioner had a previous lifting injury, that he underwent a lumbar discectomy and that he had foot drop. It was noted that the case was discussed with Dr. Klopfenstein and that Petitioner was a neurosurgery transfer. The Prehospital Care Report Summary from Galesburg Hospitals' Ambulance Service dated March 9, 2011 noted that Petitioner related that he had been having problems the last three days, that Kelly Krug, PA-C, had been treating him, that he was sitting in a chair when he developed sharp lower lumbar pain and that he denied any trauma. It was noted that Petitioner reported that most of the pain had subsided but that he felt as if his left leg was asleep. (PX1).

The records of OSF St. Mary Medical Center reflect that Petitioner underwent a History and Physical dated December 14, 2010 for left upper extremity pain/pre-operative clearance. It was noted that Petitioner was scheduled to have left carpal tunnel surgery on December 17, 2010 at St. Mary Medical Center by Dr. Gernant. Petitioner's Past Medical History was noted to include low back pain status post L4-5 discectomy in June 2010 in Springfield. The Operative Report dated December 17, 2010 noted that Petitioner underwent (1) anterior transposition left ulnar nerve elbow; (2) left carpal tunnel release by Dr. Gernant for pre- and post-operative diagnoses of (1) left ulnar neuropathy elbow; (2) left carpal tunnel syndrome. (PX1).

The physical therapy records of OSF Galesburg Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on March 8, 2011, at which time he complained of low back pain that was left greater than right and was radiating down his

left leg. It was noted that the left leg symptoms started three days prior. It was noted that Petitioner reported paresthesias to the left foot but no decreased strength of [*sic*] foot drop. Petitioner was recommended to undergo an MRI of the lumbar spine and was prescribed medications. The diagnosis was noted to be that of acute lumbar back pain. At the time of the July 25, 2011 visit, Petitioner was seen for a skin lesion located medially on the right middle finger. Petitioner underwent cryosurgery of a common wart on the right middle finger on that date. (PX2).

The medical records of Galesburg Wellness were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on December 13, 2010, at which time it was noted that he bent down and picked up his daughter's toys and had back pain radiating down the right leg. It was noted that Petitioner took muscle relaxers and Naproxen for pain. At the time of the March 7, 2011 visit, it was noted that Petitioner had low back pain radiating down his left leg. (PX3).

The medical records of Illinois Neurological Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on April 8, 2011, at which time it was noted that he was one month status post emergent left L4-5 microdiskectomy by Dr. Klopfenstein on March 9, 2011 and that he was also status post L4-5 diskectomy in the remote past. It was noted that Petitioner presented urgently on the day of surgery with acute onset of severe left foot drop and that an MRI demonstrated a large L4-5 disk herniation. It was noted that Petitioner stated that he was doing quite well, that he only had mild back pain when he first arose in the morning and that he had occasional mild left lower extremity pain. It was noted that Petitioner complained of numbness and tingling in the left great toe and second toe and that he was currently participating in physical therapy. Petitioner was instructed to continue physical therapy and to remain on activity restrictions for another four weeks. (PX4).

The records of Illinois Neurological Institute reflect that Petitioner was seen on May 20, 2011, at which time it was noted that he was doing quite well, that he had only occasional low back pain which improved after he had been up for a period of time in the morning and that he had minimal leg pain, but that he did state that he had an occasional jolt of pain down his left leg. Petitioner was instructed to slowly increase his activities and to continue physical therapy for anterior tibialis strengthening as well as general strengthening. It was noted that Petitioner had returned to work at light duty and was unable to return to full duty at that time. At the time of the July 13, 2011 visit, it was noted that Petitioner stated that he was doing quite well, that he had only mild stiffness in the morning which resolved after being up for a short period of time and that he denied leg pain. It was noted that Petitioner had an occasional sharp pain in his left great toe and numbness in the left great toe and dorsal surface of the left foot and that subjectively, he felt his left ankle weakness was improving. It was noted that Petitioner had completed physical therapy and was doing a home exercise program as well as swimming. It was noted that Petitioner was to slowly continue to increase his activities back to his usual routine and that he did not feel he was ready to return to full duty at that time as a police officer. It was noted that Petitioner required return to work without restrictions effective August 8, 2011. (PX4).

Included within the records of Illinois Neurological Institute was an interpretive report for an MRI of the lumbar spine performed on March 9, 2011, which was interpreted as revealing (1) L4-L5 recurrent disc prolapse extending into the superolateral recess on the left compressing the descending L5 nerve root and displacing thecal sac from ventral to dorsal and from left to right; the fragment extends at least 1.5 cm in length; (2) degenerative small central disc prolapses at the L2-L3 and L3-L4 levels with minimal displacement of thecal sac and without distortion of the neural elements. (PX4).

The records of Illinois Neurological Institute reflect that Petitioner was seen on June 2, 2014, at which time it was noted that he fell while on a roof on May 30, 2014 but that he did not fall from the roof. It was noted that Petitioner had immediate left buttock and left posterolateral thigh pain and was seen in the Emergency Department, that imaging studies demonstrated no fractures and that Petitioner stated he now had only mild, infrequent low back pain and that his leg pain had resolved. It was noted that Petitioner had

persistent numbness and tingling in his left great toe and the medial aspect of his left calf, which had been present since prior to surgery in 2011. It was noted that Petitioner had been taking Naproxen at bedtime and that he took a muscle relaxant for two days. It was noted that no further imaging studies and no further intervention was indicated and that he was to return to work as a police officer effective June 3, 2014. (PX4).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was discharged on March 11, 2011, at which time it was noted that he was a 45-year-old male with a history of hypertension, low back pain and previous discectomy, presenting with three days duration of left back pain. It was noted that Petitioner started experiencing back pain on Sunday and mild weakness of his left lower extremity, mainly with dorsiflexion of his left foot. It was noted that on Monday and Tuesday, Petitioner stated his weakness got progressively worse and that he had extreme back pain, complete foot drop and was not able to walk. It was noted that Petitioner underwent surgery on March 9, 2011 and recuperated without complication. Included within the records was the Operative Report dated March 9, 2011, which noted that Petitioner underwent (1) emergent left L4-5 microdiskectomy; (2) microdissection – use of operating microscope; (3) complex case – revision of lumbar surgery for a pre- and post-operative diagnosis of recurrent left L4-5 herniated lumbar disk with foot drop. (PX5).

The IME Report dated March 23, 2017 of Dr. Patrick O'Leary was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The report noted that Petitioner had been a state trooper for about 20 years, that he had had a couple of issues with his back, that he developed back problems once when he used to work in the academy as an instructor in tactics and that he had a prior injury to his back and had surgery in approximately 2002. It was noted that Petitioner had a subsequent injury which occurred some time in 2011, that he worked largely out of his squad car, and that he was lifting a bag from the back of his squad car, turned, lifted and picked it up, and his legs gave out on him. It was noted that Petitioner went to see Dr. Klopfenstein in 2011, that he had surgery on his back and that he had surgery urgently for an apparent disk herniation and a substantial amount of weakness in the left leg. It was noted that Petitioner was able to get back to work and had been working full duty ever since and that he wore an ankle-foot orthosis because he was unable to dorsiflex the left foot at all. It was noted that there were no significant findings at the time, that Petitioner felt that most of his symptoms had subsided other than the weakness that never returned and that he felt to be in reasonable shape and able to do his job. (PX6).

The report reflects that Petitioner had a steppage gait pattern, that he wore an AFO on the left ankle, that dorsiflexion of the left foot was minimal, that extensor hallucis longus function was minimal and that he had diminished sensation in the dorsal aspect of his foot from about the mid foot down to the toes. It was noted that Petitioner did not have any subjective complaints, that he had chronic weakness in the left leg but that his back pain was baseline and that he was working normal duty. It was noted that Petitioner had normal appropriate behaviors in the office. It was noted that the diagnosis was L4-L5 recurrent disk herniation status post discectomy with a left foot drop. (PX6).

The report reflects that it was a difficult dilemma for Dr. O'Leary to evaluate Petitioner at this late juncture. It was noted that it sounded to Dr. O'Leary that he had an event right around the end of 2010 in which he temporarily developed the symptoms of weakness in his legs and then a couple of months later he developed the full-blown onset of profound weakness and urinary difficulties and had emergent surgery. It was noted that there was probably a role of something that in the process of working contributed to this, particularly given the incident in his squad, within a short time later he developed full-blown onset symptoms requiring urgent surgery and therefore he thought the findings were connected in that regard. It was noted that Dr. O'Leary opined that Petitioner's medical treatment had been reasonable and necessary, that no further medical treatment was necessary at that time and that Petitioner's prognosis was excellent despite the foot drop. It was noted that Petitioner was functioning well, working full duty and had had an excellent outcome overall. It was noted that Petitioner could work as normal with no restrictions and could

do activities as normal, albeit Petitioner continued to wear his ankle-foot orthosis to avoid falls. It was noted that Petitioner had reached maximum medical improvement and would have been approximately one year after the surgery. (PX6).

The Medical Bills of Physical Therapy/Rehab OSF St. Mary's were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Medical Bills of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The Medical Bill of Galesburg Hospital Ambulance Service was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The CMS Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that Petitioner's injuries occurred on November 29, 2010 and, as such, the Arbitrator will not specifically be addressing the five factors under Section 8.1b of the Act in the determination of permanent partial disability.

The Arbitrator finds that the medical records in this case demonstrate that on March 9, 2011, Petitioner underwent an emergent left L4-5 microdiskectomy for a pre- and post-operative diagnosis of recurrent left L4-5 herniated lumbar disk with foot drop. Petitioner testified it is difficult for him to walk without his ankle brace because of the drop foot caused by his back injury. Petitioner testified that he takes Naproxen and a muscle relaxer on occasion. Petitioner also testified that he is able to satisfactorily perform his job duties and that he has had no complaints from any supervisors regarding his job performance since he returned to work.

Having reviewed the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 22.5% loss of use of the person-as-a-whole under Section (d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VICTORIA PECKINPAUGH,

Petitioner,

vs. NO: 15 WC 30588

MEMORIAL HOSPITAL OF CARBONDALE,

18IWCC0570

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, and prospective medical, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission affirms and adopts the Arbitrator's decision with the exception of the award of medical expenses. Petitioner's Exhibit 1 contains medical bills totaling $193,103.36; these charges are related to treatment of both the accepted left shoulder condition as well as the disputed cervical spine condition. Although the Arbitrator determined Petitioner's cervical spine condition is not causally related to her work accident, Respondent was nonetheless ordered to pay all the charges documented in Petitioner's Exhibit 1, including those associated with evaluation of Petitioner's cervical spine complaints. Pursuant to Section 8(a), Respondent's liability for medical expenses is limited to "that which is reasonably required to cure or relieve

18IWCC0570

from the effects of the accidental injury." *820 ILCS 305/8(a)*. Having concluded Petitioner's cervical spine condition is not an "effect[] of the [August 18, 2015] accidental injury," the Commission vacates the award of medical expenses associated with Petitioner's cervical spine. Respondent is ordered to pay the charges incurred for treatment of Petitioner's left shoulder condition pursuant to Sections 8(a) and 8.2. Respondent shall have credit for those expenses previously paid.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay the medical expenses incurred for Petitioner's left shoulder condition pursuant to §8(a) and §8.2 of the Act. Respondent shall have credit for any amounts previously paid, and Respondent shall hold Petitioner harmless for any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j).

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: SEP 19 2018

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mck

O: 7/31/18

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

PECKINPAUGH, VICTORIA
Employee/Petitioner

Case# **15WC030588**

MEMORIAL HOSPITAL OF CARBONDALE
Employer/Respondent

18IWCC0570

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:

0969 RICH RICH & COOKSEY PC
MICHELLE M RICH
6 EXECUTIVE DR SUITE 300
FAIRVIEW HTS, IL 62208

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

VICTORIA PECKINPAUGH
Employee/Petitioner

v.

MEMORIAL HOSPITAL OF CARBONDALE
Employer/Respondent

Case # 15 WC 30588

Consolidated cases: _____

18IWCC0570

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 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 _____

18IWCC0570

FINDINGS

On the date of accident, **August 18, 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 in the left shoulder *is* causally related to the accident. Petitioner's current condition of ill-being in the cervical spine *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$20,470.60**; the average weekly wage was **$393.67**.

On the date of accident, Petitioner was **23** 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 **$1,462.16** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$1,462.16**.

Respondent is entitled to a credit for any and all bills paid prior to hearing via its group medical plan under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has sustained her burden of proof that she sustained accidental injuries arising out of and in the course of her employment on August 18, 2015, and has also sustained her burden of proving that she provided timely notice of the accident to the Respondent.

The Arbitrator finds that the Petitioner has failed to prove that her cervical condition is causally related to the August 18, 2015 accident.

Respondent shall pay reasonable and necessary medical services contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

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

The Arbitrator finds that the cervical surgery recommended by Dr. Gornet is not reasonable and necessary under Section 8(a) of the Act, and that the Petitioner's cervical condition is not causally related to the accident.

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

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

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

Signature of Arbitrator

August 31, 2017
Date

SEP 12 2017

STATEMENT OF FACTS

Petitioner worked for the Respondent as a Certified Nursing Assistant (CNA) from August 2012 to September 2015. As to her daily job duties, involving patients weighing between 100 and 400 pounds, she testified: "I lifted patients. I assisted them with the daily activities. I transferred them to the bed, to other equipment. I assisted other CNAs with their patients." This involved using her upper body and both arms. Sometimes she would transfer/move patients with help from co-workers, and other times she would not have assistance.

In the spring of 2015 she started to notice sharp pain on the top of her left shoulder going down her left arm, as if someone was pulling it, and in the middle of her neck. She sought an evaluation with her primary physician, Dr. Burge, noting she felt her problem was in the shoulder.

Petitioner presented to Dr. Burge on 4/6/15, reporting a one month history of left shoulder pain, as well as noting pain with certain movement. She had been exercising five times per week. No trauma or specific injury was noted, and there was no numbness or weakness. With regard to physical examination, Dr. Burge noted tenderness in the anterior subacromial area and along the clavicle, and pain with internal and external rotation and with abduction and internal/external rotation. The diagnosis was shoulder joint pain, Petitioner was advised not to lift weights and she was prescribed Naprosyn and physical therapy. (Px3). Prior and subsequent records indicate Petitioner was involved in weight loss with Dr. Burge during and prior to this visit. (Px3).

Petitioner initiated therapy at Rehab Unlimited on 4/20/15. The initial therapist's note indicates complaints of left shoulder pain which had gradually progressed for several weeks despite the use of icing, even at work. She also noted she had been doing the "21 Day Fix" exercise program. A medical history was noted including goiter and head and neck swelling. She was noted to have excessive roundness of the bilateral shoulders, with the left shoulder slightly elevated versus the right, and tightness of the muscles of the neck and upper trapezius. The Petitioner was discharged on 6/8/15 due to her failure to return, after 3 visits and multiple cancelations/no shows, and none of her goals had been met. It was indicated she was performing a home exercise program. (Px4).

Petitioner testified that she did not feel therapy helped her condition. She followed up for the shoulder with Dr. Burge on 6/29/15 indicating no improvement with therapy. Exam noted continued tenderness with loss of range of motion, and left shoulder x-rays and MRI were ordered. On 8/3/15, Petitioner reported noticing right neck glandular swelling to Dr. Burge. Exam noted swelling was mild and medication was prescribed. (Px3).

7/21/15 left shoulder x-ray was normal other than minor arthritis, while the 8/14/15 MRI showed: moderately severe rotator cuff tendinosis with partial tear of the distal infraspinatus but no full thickness rotator cuff tear or retraction; hypertrophic degenerative changes of the AC joint with lateral downsloping of the acromion representing a possible source of impingement; joint centered marrow edema related to stress reaction or contusion without acute fracture; edema near the AC joint capsule related to low grade sprain or synovitis without abnormal widening of the joint space; suspected glenoid labrum degenerative changes; tendinosis/partial tear of the long head of the biceps; and, a small bone island within the glenoid. (Px5).

Petitioner indicated that Dr. Burge examined her shoulder, but not her neck: "She knew where my pain was, that was really it." Petitioner testified that Dr. Burge called her on 8/18/15 with the results of her MRI. Petitioner then contacted her supervisor, Patty Misker, on 8/25/15 and was referred to human resources, where an accident report was prepared. She also spoke with HR's Stephanie Phillips by phone, and she was the one who prepared a Form 45 (Px15). Petitioner testified she reported an 8/18/15 accident based on when Dr. Burge contacted her regarding the left shoulder MRI results. The accident report (Rx7) states: "My job duty requires me to lift and pull on patients and heavy objects. I have repetitive trauma on my left shoulder. My doctor called me 8/18/15 and diagnosed me with a torn rotator cuff."

After reporting the injury, Petitioner testified that Dr. Burge restricted her to light duty. Ms. Phillips sent her to another facility to work a light duty job on a temporary basis. Petitioner then contacted Patty Misker to determine if her restrictions could be accommodated on light duty, but testified Respondent wouldn't allow her to return because she wasn't able to lift patients. When she had attempted to do so, she had stabbing pain in the top of the left shoulder into the arm. Petitioner then voluntarily resigned her job with the Respondent on 9/13/15 and sought employment that didn't involve such lifting.

Petitioner testified that Dr. Burge then referred her to Dr. Brown and she had therapy at Dr. Brown's facility. The Arbitrator did not locate a specific referral in the records of Dr. Burge to Dr. Brown.

Petitioner reported to orthopedic surgeon Dr. Brown on 9/29/15 with complaints of left shoulder pain (5 out of 10 currently) since May of 2015 while working for Respondent: "She was pulling, lifting, pushing patients and developed pain in her shoulder." She reported no significant improvement with therapy and a pain patch, and was referred here following an MRI. She denied any prior problems with either shoulder or similar complaints in the right shoulder. Examination noted mild AC joint tenderness, mild pain with O'Brien testing, 2 of 3 impingement signs and increased pain with resisted infraspinatus testing. Dr. Brown's review of the left shoulder MRI indicated a slight increased signal in the infraspinatus region and possible partial thickness articular tear versus tendinosis, but no definite signs of labral tear or pathology. There was some edema and changes in the AC joint. Dr. Brown believed Petitioner likely had rotator cuff impingement and possible mild AC arthrosis and/or mild biceps tendinosis. He gave her a prescription for Voltaren Gel and a rotator cuff physical therapy program with modalities over the AC joint, and allowed her to continue to work full duty. The report was copied to Dr. Burge. (Px6).

Interestingly, Dr. Brown's records contain two separate intake forms, one from 8/26/15 and the other from 9/29/15. The 8/26/15 form notes a few months of left shoulder pain which she indicated was due to lifting and pulling patients at work for three years, with no specific trauma. The 9/29/15 form, which is when she initially saw Dr. Brown, reports basically the same thing, noting she was working full duty ("new job doesn't require me to lift or push/pull"), but that the injury occurred on a specific date, 8/18/15, and that her injury was to the rotator cuff, post-MRI. (Px6).

Physical therapy records from the Orthopaedic Institute of Southern Illinois confirmed that Petitioner participated in therapy to improve mobility and strength in her left shoulder, and that Petitioner's pain dated back to the spring of 2015 and had been gradual in onset due to work activities as a CNA. (PX6).

On 11/3/15, Dr. Brown noted Petitioner felt she was improving with range of motion and strengthening therapy, but continued have left shoulder pain, pointing to her AC joint. She reported increased pain with overhead activities and reaching across. Physical exam noted pain to palpation and with exam testing, but full strength and range of motion. Dr. Brown recommended continued physical therapy, to specifically address her AC joint arthrosis, which therapy had not been doing. If she failed to improve, he recommended a cortisone injection. Full duty was continued. (Px6).

With regard to the therapy performed at Dr. Brown's request into November 2015, the Arbitrator located no evidence of complaints regarding the neck, headaches or tingling into the arm or fingers. (Px6).

Petitioner returned to Dr. Brown on 12/9/15, reporting that her symptoms were getting worse, with daily migraines, pain that radiates from the base of her skull into her upper trapezius and shoulder area, as well as numbness and tingling of her bilateral hands with movement of the neck including flexion, extension and rotation. She was still working full duty, noting she was able to tolerate it because it currently didn't involve any heavy lifting or push/pulling. Following exam, which included the neck, Dr. Brown stated he believed Petitioner continued to have difficulty with a painful AC joint, but that her symptoms seemed to be spreading or even emanating from her cervical spine. He told Petitioner it may just be due to posturing on her part, but would nevertheless request approval from workers' compensation to evaluate Petitioner's neck. She remained on full duty status.

While the therapy did help with range of motion and strength, Petitioner testified her pain continued, and she began to notice more neck symptoms. As her shoulder improved, her pain radiated into her arm and the base of her neck with headaches, and numbness and tingling into the forearm and fingers, which she reported to Dr. Brown. The PT records in November 2015 indicate the Petitioner had reached all of her goals other than reducing her pain to 0/10. Petitioner did not recall Dr. Brown ever examining her neck. They agreed to try more therapy before attempting a shoulder injection, but she testified she didn't feel she was going to improve with PT, so she sought a second opinion. She requested a referral from Dr. Burge to Dr. Mall based on a recommendation from her attorney.

Petitioner initially visited Dr. Mall on 2/5/16. His report notes complaints of shoulder pain and "cervical spine symptoms", and that she had reported a work injury in May of 2015 while employed with Respondent where she had to do a lot of pushing, pulling and lifting of patients. She reported that this caused her to develop bilateral shoulder pain, left much greater than right, as well as radicular-type symptoms which were also left greater than right. She was working at a new job which did not involve as much of these types of activities. After examining Petitioner and reviewing the left shoulder MRI, which he notes showed a SLAP tear and substantial AC joint inflammation with some fluid around the bicep but no rotator cuff tear, the diagnoses were AC joint inflammation, SLAP tear and rotator cuff tendinitis, as well as cervical spine inflammation and possible disc injury. Dr. Mall recommended a cortisone injection into the AC and glenohumeral joints of Petitioner's left shoulder, as well as physical therapy, and he referred Petitioner to spine surgeon Dr. Gornet for a cervical evaluation, as Dr. Mall believed a portion of Petitioner's symptoms were coming from the neck. Following the injection on 2/5/16, Petitioner on noted almost complete resolution of her pain, with Mall indicating that many of her symptoms were related to her shoulder. However, he believed some additional symptoms were related to her cervical spine, as these symptoms were not resolved with the injections. With regard to causation, Dr. Mall indicated that pushing, pulling and lifting were considered shoulder-intensive exercises and could aggravate the

AC joint and cause inflammation, as well as biceps tendon injuries, biceps tendon inflammation and possible superior labral tears. His review of Petitioner's medical records indicated her symptoms were consistent since her reported injury, and as a result, that her current symptoms were causally connected with her job duties while working for Respondent. (Px7). Petitioner testified she reported the same symptoms to Dr. Mall as she had previously reported to Drs. Burge and Brown.

On 2/6/16, a note from Dr. Brown's office indicated the Petitioner was seen in the office and that "Scott" wanted to get an x-ray and MRI of the cervical spine to rule out a cervical cause of her shoulder pain. (Px6).

On 2/11/16, Petitioner appeared at the Southern Illinois Hospital ER with complaints of left shoulder and neck pain and a 3 week history of difficulty swallowing. She noted the shoulder and neck pain began in July 2015 lifting patients at work. She reported the pain radiated from the neck to the left shoulder and arm with shooting to the fingers at time. A cervical CT scan was performed reflecting no acute osseous cervical abnormalities with normal alignment and patent spinal canal. There were also no specific findings to account for the swallowing issues. The diagnoses were cervical radiculopathy and dysphagia, and she was referred to Dr. Tibrewala or other GI specialist, and advised to follow up with her orthopedic / spinal surgeon. (Px5). On 3/2/16, Dr. Mall recommended arthroscopic surgery, as she had good shoulder function and thus didn't think that therapy would offer substantial improvement. (Px7).

Petitioner initially saw Dr. Gornet on 2/16/16, with complaints of the left shoulder, left upper arm pain and pain down her left arm into her hand. She also reported bilateral trapezial pain, neck pain and headaches, as well as right-sided shoulder and upper arm pain and tingling, but to a lesser extent than the left side. Petitioner reported the onset of symptoms in approximately May 2015 while working as a CNA and, "during that period involved moving a significant amount of patients, pulling them up in bed, transferring them from bed to chair and vice versa." She reported noticing increasing shoulder pain during this activity, and that the symptoms were bilateral. She did not recall prior significant neck or shoulder problems, but admitted to occasional chiropractic care, the last time being 3 to 4 years prior. She continued to suffer from daily headaches as well as bilateral shoulder and arm symptoms, left greater than right, and that she continued to work full duty in a lighter job. Physical examination revealed a decrease in wrist volar flexion and dorsiflexion on the left at 4/5, as well as pain into Petitioner's neck, both trapezius, upper back, bilateral shoulders, left greater than right and down both arms into her hands. Cervical x-rays were normal. Dr. Gornet interpreted the cervical MRI to show an obvious annular tear at C5/6 with a left-sided herniation, and a small C4/5 disc protrusion which he did not believe accounted for a significant portion of her symptoms. Dr. Gornet believed Petitioner's current symptoms were causally connected to her work injury, and stated that her complaints of bilateral shoulder and upper arm symptoms were consistent with a cervical spine injury and referred pain. He recommended a steroid injection at C5/6 and opined that she could continue to work full duty in her telemetry job. (Px8).

Petitioner also filled out a patient pain drawing at the 2/16/16 visit, and indicated the presence of aching, stabbing and pins and needles in her neck and both shoulders, worse on the left side. An intake form notes neck pain and tingling/numbness in fingers. (Px8). The 2/16/16 cervical MRI report indicates a central broad-based protrusions at C4/5 and C5/6 with mild bilateral foraminal stenosis at C5/6 and no central canal stenosis, as well as a left foraminal protrusion at C3/4 resulting in mild left foraminal stenosis. (Px11).

Petitioner underwent a Section 12 examination with Dr. Nogalsky on 3/2/16 for the left shoulder. The report documented Petitioner describing having left shoulder pain sometime around May of 2015, similar to a pulled muscle, as well as pain at the top of the shoulder. She had started to notice, over the past several weeks, some numbness on the right side more than the left around the thumbs, as well as some numbness in her index and middle fingers. Dr. Nogalski documented a cervical examination on this date. He noted full motion with some

complaints of pain at the extremes of flexion and extension. Petitioner had pain in the left greater than right paraspinous muscles. Mild midline tenderness was noted in the lower cervical spine. Spurling's tests were negative, and neurovascular exams of both upper extremities were intact. Dr. Nogalski's impression was of discal clavicular edema, greater than age appropriate tendinopathy of the rotator cuff, and possible mild biceps tendinopathy. He stated Petitioner had no specific neck problem due to her claimed injury. He believed that if she continued to have pain for 2 to 3 months, arthroscopic left shoulder surgery could be considered. (Rx8).

On 4/15/16, Dr. Mall noted Petitioner questioned Dr. Nogalski's report regarding the lack of neck complaints in Dr. Burge's records, and his indication she had been weightlifting when she was lifting only using 5 pound weights in home exercise. Dr. Mall agreed that the AC joint was one of Petitioner's major issues, but also felt the bicep and SLAP tear were major issues that needed to be addressed. He disagreed with Dr. Nogalski's recommendation for more rest given a year had passed since symptoms began, and continued to recommend surgery. (Px7).

Dr. Boutwell performed a left C5/6 epidural on 3/17/16. (Px9). Petitioner testified that the epidural helped for about 2 weeks before she returned to her baseline condition. At 5/2/16 follow up with Dr. Gornet, he reiterated he believed the majority of her symptoms were coming from C5/6, and he recommended cervical disc replacement at that level. He noted the majority of her symptoms were neck and headaches. (Px7).

Dr. Mall performed extensive debridement of the rotator cuff and superior labrum, subacromial decompression, acromioplasty, AC joint resection arthroscopically, as well as open biceps tenodesis on 6/23/16, and Petitioner was held off work. Following surgery, Petitioner testified she had shoulder improvement, but her neck symptoms became worse. Following physical therapy and oral steroids, on 8/29/16 Petitioner reported her shoulder was basically pain free, and she was released from care and to full duties. (Px7).

Petitioner was examined at the Respondent's request by Dr. Bernardi on 9/6/16. (Rx2). Petitioner reported neck and left shoulder problems she attributed to repetitive work with the Respondent, noting she first noticed problems in the spring of 2015, and denied any prior significant or sustained neck or left shoulder problems or treatment prior to her employment with Respondent. Petitioner reported that, as a CNA, she had to routinely help patients to transfer and change positions. She started to develop tightness over the superior left shoulder blade, associated with stabbing in the left AC joint and pain over the lateral shoulder. At the visit, Petitioner reported pain along the left neck, extending over the top of the shoulder blade, radiating down the anterior arm and forearm to the 2nd and 4th digits as a numb sensation. She reported similar symptoms in the right arm but not nearly as severe, as well as a very sharp pain that involved the bilateral neck radiating up to her ears. Following review of prior medical records, cervical MRI and examination, Dr. Bernardi diagnosed mild C5/6 degenerative disc disease and periscapular, shoulder and non-radicular arm pain of uncertain etiology. He indicated his review of the cervical MRI indicated it was essentially normal with "extraordinarily" minor C5/6 degeneration, with no evidence of herniation of stenosis. As to the references in Petitioner's medical records to exercise for weight loss, Petitioner indicated this involved only walking. Dr. Bernardi indicated that a structural problem in the cervical spine can cause axial pain, with relatively minor involvement of the extremities, but that no structural injury he is aware of takes weeks to months to become symptomatic. Petitioner agreed she had no specific trauma. There was no evidence of cervical nerve compression. Dr. Bernardi opined that the left shoulder symptoms Petitioner complained of to Dr. Burge on 6/29/15 were not consistent with a neck problem. All of her initial complaints referenced only the left shoulder. He noted her 9/29/15 pain diagram for Dr. Brown showed only anterior and posterior shoulder discomfort, and no symptoms in the left suprascapular or interscapular regions, though he did note in the Review of Systems section Petitioner mentioned left side of neck hurts from pressure sometimes my left hand tingles." It then was not until 2/5/16 that Dr. Mall mentioned neck tenderness and loss of cervical range of motion and radiating arm symptoms. Dr. Bernardi stated: "Also,

for the first time these symptoms were bilateral. I find this very strange. (Petitioner) stopped working at (Respondent) in September 2015. She took a less demanding job at Heartland that same month. If her symptoms were due to repetitive activities, it seems to me that they should have subsequently either plateaued or improved. Instead, they seem to have progressively worsened. In the 4 or 5 month interval between her job transition and her first visit with Dr. Mall, she developed shoulder pain on the right, bilateral arm pain and worsening neck discomfort. I do not know how to explain this." As to the 9/29/15 review of systems, he noted it is "somewhat vague", and that he couldn't imagine a structural or neurological spine problem that would initially manifest as local shoulder pain in May and then as neck pain almost five months later, and that this strongly argued against a causal connection. He reiterated that her MRI was essentially normal, and the minimal degeneration seen at C5/6 was unrelated to her work activities. Dr. Bernardi stated that if her problem were myofascial, it would have resolved by now. He indicated he didn't know why the cervical spine was even implicated in this case, "particularly when her presentation is so atypical." He did not see an annular tear or a herniated disc at C5/6, noting he had a neuroradiologist also review the film and came to the same conclusion. He opined she did not need any further cervical treatment, and certainly didn't require a disc replacement. He believed she was at MMI and needed no work restrictions. (Rx2).

On 10/3/16, Petitioner reviewed Dr. Bernardi's report with Dr. Gornet, who indicated "Dr. Bernardi and I have very different opinions regarding structural problems in the spine", and that while he agreed there was no evidence of nerve compression, structural abnormalities like that seen at C5/6 cause symptoms consistent with structural or axial neck pain, and caused an inflammatory and chemical change in that environment which causes persistent paresthesias or tingling, and headaches. (Px7).

Petitioner returned to Dr. Mall on 10/27/16 with some posterolateral shoulder pain, noting she had been doing her home exercise, but with 5 pound weights. She was given an injection and prescription for Medrol dosepak, noting she was unable to take anti-inflammatories. On 12/1/16, he noted she had some very mild ongoing symptoms but otherwise had regained her full strength, and he again released her from care with a home exercise program. (Px7).

On 11/7/16, Petitioner underwent a cervical CT scan/myelogram. Dr. Gornet indicated it did not show significant nerve compression, but did show clear central disc protrusion/annular tear at C5/6. There was no significant facet arthropathy, and Petitioner reported continued shoulder pain. Full duty was continued. (Px7). The myelogram report notes no significant stenosis and mild diffuse disc space narrowing, and the CT report notes mild degenerative changes at C2/3 and C4/5, and no abnormalities at any other level. (Px12). Petitioner followed up with Dr. Gornet on 1/12/17 and 5/1/17. He reiterated the surgical request, prescribed medication and continued Petitioner on full duty work. (Px7).

Board certified orthopedic surgeon Dr. Gornet testified via deposition on 11/7/16. A specialist in the spine, he testified to significant experience with regard to cervical disc replacements. Dr. Gornet noted Petitioner's onset of shoulder pain in May of 2015, and that Petitioner had been employed as a CNA for Memorial Hospital of Carbondale, where she had performed a significant amount of patient lifting, pulling them up in bed and transferring them. The only abnormality he noted on exam was a slight decrease in wrist volar flexion and dorsal flexion on the left at four over five. He also confirmed that her cervical spine x-rays revealed well-preserved disc height and no significant degeneration. Dr. Gornet testified that her cervical spine MRI revealed an obvious annular tear at C5-6 and a small protrusion at C4/5. During his deposition, Dr. Gornet produced two views from Petitioner's MRI, which were admitted into evidence as Petitioner's deposition exhibits 2 (Image 7) and 3 (Image 8). Dr. Gornet identified exhibit two (2) as a left foraminal view, and drew a line up to the disc protrusion he identified at C5/6, as well as the smaller protrusion at C4/5. Dr. Gornet testified that the disc at C5/6 protruded out, and was clearly different than Petitioner's other levels, which was indicative of a low-level

disc herniation or protrusion. Dr. Gornet indicated this finding was consistent with some of Petitioner's arm symptoms. Dr. Gornet testified exhibit 3 showed an annular tear at C56, which Dr. Gornet identified by circling. He described an annular tear as a structural loss of integrity of the disc and the annulus itself at C5-6. (Px13).

Dr. Gornet testified that medical literature confirms that structural injuries to the cervical discs are known to cause structural neck pain and headaches. He opined that Petitioner suffered from a structural injury to her cervical spine at C5/6. Injection provided Petitioner with temporary relief of her symptoms. Dr. Gornet also described the shoulder and neck as "watershed" areas, meaning that cervical spine problems can manifest as shoulder pain and arm symptoms, and vice versa. He stated that it was extremely common to see pathology in both the shoulder and cervical spine because cervical spine pathology can come from mechanical loading to the arms into the cervical spine. (Px13).

Although Petitioner acknowledged an improvement in some of her symptoms following shoulder surgery, Dr. Gornet testified that she reported she still suffered from symptoms, which he believed were due to the C5/6 level due to correlation with the symptoms. Dr. Gornet testified that by performing a disc replacement, he would be removing the source of irritation and inflammatory effect, and would provide a better outcome and an earlier return to work as opposed to a cervical fusion, as well as reduce the risk of adjacent level problems that can occur with fusion. Dr. Gornet disagreed with Dr. Bernardi's opinion that surgery should not be performed because there was no evidence of radiculopathy. He agreed Petitioner had no nerve compression or radicular symptoms, but referenced his own peer-reviewed study, which demonstrated the results of treating patients with structural neck pain independent of any nerve compression were better than those with radiculopathy or myelopathy. Dr. Gornet noted that the cervical CT myelogram was performed to confirm there was no facet arthropathy, as such condition would contraindicate disc replacement surgery. Dr. Gornet disagreed with Dr. Bernardi's conclusion that Petitioner needed no further treatment. (Px13).

On cross-examination, Dr. Gornet testified that he would associate Petitioner's neck pain, headaches, and shoulder pain to the pathology he identified in her cervical spine, based on these symptoms correlating with the objective pathology seen on her MRI scan, and was also confirmed by the temporary relief she experienced following the epidural injection. He agreed with Dr. Bernardi that Petitioner was not suffering from significant nerve compression, but could have secondary nerve irritation from her disc pathology. Dr. Gornet agreed that the radiologist, Dr. Ruyle, did not note a C5/6 annular tear in the MRI report, but did not know which films Dr. Ruyle reviewed. Dr. Gornet believed the C5/6 annular tear was caused by Petitioner's lifting activity. Dr. Gornet testified that C5/6 level had a protrusion on one side and the annular tear on the other, and was the only level of bilateral pathology, and it correlated with her overlapping watershed area in which symptoms can manifest in the shoulder. Dr. Gornet also stated that Petitioner's clinical picture was consistent with his experience in treating like or similar patients who had significant neck pain and headaches. (Px13).

When asked if structural neck disc injuries could develop over time or if their onset was more immediate, Dr. Gornet testified that patients can experience a constellation of symptoms which could evolve over time, as most symptoms and illnesses do. He further explained that the most common scenario with regard to structural neck pain would be a whiplash injury in which a patient had a structural injury to the disc, but did not have significant compression or pathology. Dr. Gornet stated that his success rate in treating these types of patients made him very confident that he could help Petitioner's condition improve. (Px13).

Subsequent to Dr. Gornet's testimony with regard to the cervical MRI, the radiologist who interpreted that study, Dr. Ruyle, testified via deposition on 1/10/17. He did not see evidence of degeneration in the cervical spine. He testified that he agreed with Gornet that the films showed disc protrusions at C4/5 and C5/6. (Px13,

Depx2, Image 7). He also agreed that another image did show a C5/6 annular tear. (Px13, Depx3, Image 8). Dr. Ruyle conceded he did not identify any annular tear at C5/6 when he originally reviewed the MRI films and prepared his report. He noted that annular tears can be very subtle findings, and that it was probable that he missed it at the time of his report. On cross exam, Dr. Ruyle testified that he reviewed Image 8 at the time of his initial review of the MRI. He agreed he did identify an annular tear at C3/4 based on Image 8 but did not identify a C5/6 annular tear in the same image at the time of his report. He also testified that he agreed with Dr. Gornet that there was a left sided C4/5 central disc protrusion in Image 7. Dr. Ruyle also testified that a person can have pathology on an MRI that may not be symptomatic, which is why clinical correlation of MRI findings is important. (Px14).

Board certified neurosurgeon Dr. Bernardi testified via deposition on 3/22/17. Dr. Bernardi understood Dr. Gornet to have diagnosed Petitioner with a structural injury to her C5/6 disc, an annular tear, with resultant discogenic neck pain. He testified that he and Dr. Gornet agree that Petitioner does not have radiculopathy. Dr. Bernardi testified that spinal discs deteriorate and degenerate as part of the normal aging process, and that approximately 80 percent of people have some evidence of disc degeneration in at least one disc by age 40. Such degeneration or deterioration of a disc does not necessarily imply the presence of pain, and in fact is usually not painful, as many of this percentage of people with such discs have no symptoms. He agreed they can become painful, but in the neck these episodes of pain tend to be self-limiting, and the vast majority of people have resolution of their symptoms within four to six weeks. (Rx1).

Dr. Bernardi is unconvinced about the existence of such posttraumatic discogenic pain, where a disc can be injured acutely in such a manner so as to release inflammatory products and result in a neck ache. He testified that the diagnosis is almost entirely confined to the medical-legal arena, and Dr. Bernardi testified he has never seen a patient suffering from so-called posttraumatic discogenic pain in his 23 years of practice. He testified that such a diagnosis is very easy to assert, and essentially impossible to prove or disprove, as it is not associated with any definable concrete set of symptoms. There are no findings on physical or neurological exam supporting such an assessment, and the imaging studies tend to show the same kind of degenerative findings seen often in the general population. Dr. Bernardi testified that when someone ruptures or herniates a disc, which is a very definable thing, it often takes several hours before they start to have symptoms, but not months. He testified that when trying to establish a diagnosis, particularly where a surgical procedure is at issue, one must have very specific complaints that correlate with the person's physical and neurological findings and imaging studies. (Rx1).

Dr. Bernardi testified that the medical literature (from the American Society of Neuroradiology, the American Spine Society, and the North American Spine Society) recommends not using the term annular "tear", as it implies a traumatic cause, and indicates the proper term is a fissure, or high-intensity zone, and these are simply manifestations of degenerative disc disease due to disc aging and loss of water content. He does not believe that such fissures are of no clinical significance. He noted that while Dr. Ruyle testified that he used this same literature to define more significant disc abnormalities, he then goes on to use the term annular tear in opposition to this literature. (Rx1).

Dr. Bernardi testified that annular fissures are asymptomatic most of the time, as 40% of adults have at least one of these, and since 40% of the population isn't having neck pain, it stands to reason. However, given that 40% of the population have them, when someone develops neck pain and have MRI, 40% of them will have an annular fissure present on an MRI. Additionally, the side to which the annular fissure exists does not necessarily correlate with the side of the neck on which the person has pain. (Rx1).

When Dr. Bernardi examined Petitioner on 9/6/16, she reported left-sided neck pain extending over the top of her left shoulder blade, extending down the front of her left arm and forearm, and terminating as a numb and tingling sensation in the second and fourth digits of her left hand. She also reported similar but much less prominent arm pain on the right, and periodically very sharp neck pain involving both sides of her neck and extending up behind her ears. He testified that these subjective complaints do not specifically correlate with C5/6, or any other level, but rather potentially could correlate with multiple cervical levels, and as such are very nonspecific, in addition to the fact that the findings at C5/6 are so minimal. (Rx1).

Petitioner told Dr. Bernardi that in the spring of 2015, she first noticed symptoms in three different areas: a pulling pain over her left shoulder blade; sharp stabbing pain in her left AC joint, and pain on the lateral aspect of her shoulder. She categorically denied any acute event, and instead attributed her symptoms to the repetitive nature of her work. Petitioner was not employed by Respondent on the date Dr. Bernardi examined her, having left employment with Respondent in September of 2015. In reviewing the records of Dr. Burge, Dr. Bernardi notes no subjective complaints of neck pain prior to Petitioner leaving employment with Respondent, as everything referenced the left shoulder. Petitioner's physical therapy records from 8/15 to 11/15 also did not document complaints of neck pain, and Dr. Bernardi testified the movements the therapist documented as tending to aggravate Petitioner's symptoms were consistent with a shoulder problem. He testified that this is one of the characteristics in distinguishing between neck and shoulder symptoms. (Rx1).

In his review of Dr. Brown's records, Brown first saw Petitioner after she left Respondent's employ, and he did not document any subjective complaints of neck pain on 9/29/15, nor did he document any complaints of right shoulder pain. Dr. Bernardi did agree that in an intake form from that date, the Petitioner indicated she was experiencing left-sided neck pain and intermittent tingling and numbness in her hand, however she also completed a pain diagram which showed only pain along the anterior and posterior aspects of her left shoulder. Dr. Brown did not document any complaints of neck pain at the next visit of 11/3/15, and his assessment continued to be entirely directed at Petitioner's left shoulder. (Rx1).

Reviewing the records of Dr. Mall, Dr. Bernardi testified that things had changed quite a bit in the three months since Petitioner saw Dr. Brown in terms of Petitioner's subjective complaints. Dr. Mall documented bilateral shoulder pain, worse on the left, and bilateral arm symptoms he believed were suggestive of cervical radiculopathy. He documented diminished range of motion of the cervical spine and a positive Spurling's test, which is a test for radiculopathy. Dr. Bernardi testified that the history of onset of these symptoms indicated by Dr. Mall was inaccurate based on the prior treatment records, as it stated all of the reported symptoms began started while employed by Respondent in May of 2015. Dr. Mall's report was the first reference Bernardi saw to bilateral shoulder pain, neck symptoms, or bilateral arm symptoms anywhere in Petitioner's records. (Rx1).

Dr. Bernardi testified that Petitioner's 2/16/16 cervical MRI showed "very, very, very minor degenerative disc disease at the C5-6 level, so minor as to almost not warrant mentioning", and all other levels of her cervical spine were normal. While he did see the presence of a little tiny white dot on one foraminal image (Image 8) of Petitioner's cervical MRI, Dr. Bernardi did not believe this dot represented an annular fissure, but rather was artefactual, as no other view of this disc showed the same finding. It was only visible on Image 8, and was not present on the images immediately before or after, and also was not visible on the saggital or axial images. He testified that when you only see a finding on one image of one slice of one view, the genuineness of the finding is at issue. (Rx1).

Dr. Bernardi reviewed Dr. Gornet's 2/16/16 report, which indicates Petitioner had complaints of neck pain, bilateral trapezius pain, bilateral shoulder pain worse on the left, and occasional headaches which developed fairly early on, which suggested her symptoms were being referred from her cervical spine. Dr. Bernardi noted,

again, that the Petitioner's prior records do not support this, as the very earliest documentation of neck complaints was in September of 2015 with Dr. Brown, and according to the form, the subjective symptoms were entirely lateralized to the left. The first time there is mention of bilateral shoulder symptoms or any neck symptoms was when she saw Dr. Mall in February of 2016. Dr. Bernardi noted Dr. Gornet's exam findings of weakness in flexion and extension of the left wrist, and testified that wrist flexion is connected to the C8 level, while extension can be connected to the C6 and/or C7 levels, and he saw no evidence of pressure on any of these three nerve roots per MRI. (Rx1).

According to Dr. Bernardi's testimony, the medical literature does not support the utility of any kind of neck surgery to treat a neck ache. The literature supports surgery to treat spinal cord compression and radiculopathy. Disc replacements have been approved for the latter purposes. As Dr. Gornet agrees Petitioner does not have radiculopathy, accordingly no surgery is indicated, be it a disc replacement or fusion. He testified that while Dr. Gornet has the right to perform a disc replacement for the stated purpose of a structural disc problem, such use would be considered an off-label use. Bernardi testified that the fact that Petitioner has ongoing symptoms is not an indication for surgery: surgery can fix certain things, and cannot fix other things. There is sound literature to against performing neck surgery on people who are not experiencing radicular pain. (Rx1).

Dr. Bernardi does not see any real abnormalities in Petitioner's cervical spine, and he found no physical exam finings correlating to C5/6, or any other level of Petitioner's cervical spine. Her neurologic exam was normal. She has a documented left shoulder problem with complaints and imaging studies referable to her left shoulder. He testified that even if you assume there is a C5/6 annular fissure, surgery would still not be indicated given the rest of the findings. The purpose of an MRI is only to confirm a clinical impression. If you work from the MRI backwards, you get into trouble because there are so many abnormalities in the neck that may be visible on an MRI. Again, he testified that an annular fissure is a degenerative finding, and Petitioner's work activities would not cause or contribute to degenerative disc disease. Dr. Bernardi testified that there is a large body of evidence including multiple studies that show annular fissures and degenerative disc disease are a genetic process. A disc herniation/extrusion associated with nerve root displacement can be correlated with appropriate radicular arm pain. Dr. Bernardi testified that headaches, like neck aches, are very nonspecific symptoms, and can be due to multiple possible causes. Petitioner's description of headaches radiating bilaterally up to behind her ears is specifically not a characteristic of discogenic headaches, which are almost always unilateral, not bilateral. In fact, he testified that headaches are not commonly related to cervical findings. He also noted that a 2013 medical report of the Petitioner referenced headaches at that time, well before the spring of 2015. (Rx1).

Dr. Bernardi was critical of Dr. Gornet's hypothesis concerning how a disc injury releases inflammatory products that cause pain. For example, patients with a disc extrusion, which is the most blatant example of a true, posttraumatic annular tear, never have neck pain; rather, the pain is completely confined to the arm. In fact, it is characteristic that such patients do not realize they have a neck issue at first because their neck does not hurt, believing instead that they have an arm problem. If Dr. Gornet's hypothesis concerning the release of inflammatory products when a disc is injured is accurate, Dr. Bernardi questioned why such patients would not have neck pain in the face of a true annular tear. A discectomy leaves a disc intact, but cuts a big hole in the disc where the disc materials come out, and such patients also do not have neck pain following surgery despite the annulus being damaged during surgery. He testified it therefore is not as clear-cut obvious that such a disc injury reliably produces these types of neck pain as indicated by Dr. Gornet. (Rx1). Dr. Bernardi did concede that neck and shoulder issues can be challenging to distinguish between given their interrelationship, but it is usually possible to sort out between the two, and that this case is no exception. (Rx1).

On cross exam, Dr. Bernardi confirmed that someone in their 20's would have a much lower risk of degenerative spine findings than someone in their 40's or 50's, and that only approximately 5% of his patients

are in their 20s. He acknowledged that Petitioner had no documented preexisting neck or shoulder symptoms, and that Dr. Burge and Dr. Brown limited their exams to the shoulder. Dr. Bernardi also acknowledged that the job duties of a CNA included patient lifting and transfers, and that performing those types of activities, including lifting and transferring of patients, could put forces through the shoulder and neck, and could cause a previously asymptomatic degenerative disc to become symptomatic. Dr. Bernardi also stated that he would defer to Dr. Mall or Dr. Nogalski with regard to Petitioner's shoulder condition. (Rx1).

Dr. Bernardi confirmed when he saw Petitioner 2-1/2 months after shoulder surgery, she complained of pain along the left side of her neck extending over the top of her shoulder blade which radiated down the anterior aspect of her left arm and forearm, and that these symptoms, with the exception of her hand, could be consistent with C5 or C6 pathology. Dr. Bernardi also testified that he did not believe Petitioner exhibited any signs of symptom magnification or malingering, and that she was very cooperative and pleasant throughout his examination. Dr. Bernardi agreed that in his practice, he has identified pathologies on a second MRI viewing that he did not initially identify. Dr. Bernardi confirmed that he attended school with Dr. Gornet and that they are friends, and believes him to be a very good doctor and surgeon, but that they have a philosophical difference with regard to indications for surgery. He acknowledged that while he himself does not perform disc replacements for his own reasons, in the right situations he is not against their use. He indicated he was aware of Dr. Gornet discussing in deposition his involvement in studying long-term outcomes of individuals who had undergone cervical disc replacements, and that the studies have shown successful outcomes, but testified that this "runs directly against a very large body of literature that says the opposite." Other than reading Dr. Gornet's deposition, he had no other information regarding these studies. Dr. Bernardi testified that while it is possible an annular tear could cause symptoms, he did not believe that to be the case, and indicated that you cannot say it does because it doesn't produce a finding that is statistically associated with the presence of symptoms. With regard to the injections that Dr. Gornet ordered and which Dr. Boutwell performed, Dr. Bernardi agreed that these could be diagnostic in nature, and that he occasionally used these in his own practice, but only when he is trying to distinguish a pain generator among abnormalities at multiple levels, and even then the determination is not precise. (Rx1). .

With regard to Petitioner's symptoms, Dr. Bernardi agreed that Petitioner's arm pain into the anterior aspect of her left arm and forearm was in the distribution of either C5 or C6, but on redirect notes that the anterior complaint is but one of multiple complaints Petitioner had, and you can't just pick and choose the symptoms you like. Dr. Bernardi agreed that there was no history of any other injury to Petitioner's cervical spine other than her relation of her symptoms to her job duties for Respondent, and acknowledged that relatively minor loads or trivial trauma can cause a previously degenerated disc to herniation or rupture. (Rx1).

Testimony was obtained on 2/7/17 from Dr. Hachigian-Gould pursuant to a Utilization Review report authored by the board certified orthopedic surgeon on 10/17/16 with regard to the reasonableness and necessity of Dr. Gornet's proposed C5/6 disc replacement surgery. Much discussion of the records reviewed was had, and multiple objections made by both sides in this case. Much of the testimony and objections did not relate to relevant information in the Arbitrator's view. The key testimony from Dr. Hachigian-Gould involved whether the recommended procedure was reasonable and necessary under current orthopedic standards. Dr. Hachigian-Gould reviewed records from Dr. Brown, Dr. Mall, and Dr. Gornet. She also reviewed the MRI films testified to by Dr. Gornet, Dr. Bernardi and Dr. Ruyle. She testified that she has reviewed numerous cervical MRI films in her career, which includes the identification of annular tears, though she agreed she has not performed surgery since 2013 and has since only been involved in medicine from a utilization review perspective. She agreed that Dr. Gornet's findings of decreased strength and volar flexion of the left wrist could possibly have correlated to either the C5/6 or C6/7. Dr. Hachigian-Gould reviewed both the cervical MRI and the enlarged

Image Number Seven and Image Number Eight from Dr. Gornet's deposition, and testified that she did not appreciate an annular tear at C5/6. (Rx4).

Dr. Hachigian-Gould testified that cervical disc replacement is under study and considered to be investigational in the United States for treatment of degenerative disc disease, and therefore it is not reasonable and necessary treatment. She agreed she based this on ODG guidelines, but that those guidelines refer to the current medical literature, and that current medical literature indicates a lack of consensus in the peer-reviewed, evidence-based literature for doing any surgical procedure for degenerative disc disease of the cervical spine. The procedure has been approved by the FDA and thus has advanced from the "experimental" stage to the "investigational" stage, but that there is currently no long-term outcomes data (which she identified as requiring 7 year outcomes) in the peer-reviewed, evidence based English medical literature. In fact, she testified that there currently is no cervical surgery Dr. Hachigian-Gould would have recommended for Petitioner based on no consistent motor or sensory deficits at C5/6. "So, consequently, there is a lack of consensus in the peer-reviewed, evidence-based literature for doing any surgical procedure for degenerative disc disease of the cervical spine." (Rx4).

Prior to this utilization review, Dr. Hachigian-Gould had reviewed cervical MRIs many times, and though she does not herself perform spinal surgery, has identified annular tears on cervical MRIs many times in her 31 years of active practice. (Rx4)

Petitioner testified that she wants to undergo the C5/6 disc replacement surgery with Dr. Gornet because she wants to be able to work as a nurse, noting she is attending nursing school and plans to obtain her bachelor's degree by December 2018. She has been working as a telemetry technician at Heartland Regional M.C.(since September 2015, and works as a licensed practical nurse (LPN)at Wexford Health Source, which are physically easier jobs. She has only missed a few days of work due to appointments. Petitioner testified she continues to have daily migraines from the base of her neck into her ears. She still has some level of shoulder pain with her neck. She has problems with prolonged standing and sitting, as well as difficulty sleeping. Her symptoms have never completely resolved since Spring 2015.

Petitioner testified that she received TTD while she was off work for the shoulder surgery.

With regard to the Section 12 examinations with Drs. Nogalsky and Bernardi, Petitioner again testified that she provided them with the same history of symptoms as she had with her treating physicians, and cooperated with them as best she could.

Petitioner agreed on cross examination that she initially reported only a left shoulder injury to the Respondent, which is consistent with the accident report in evidence (Rx7), testifying: "I did not know what else was going on.". When she left her employment with the Respondent, she agreed she remained under work restrictions that the Respondent was accommodating. She testified that this accommodation was temporary, and she still had a week or two to work when she resigned, but "I took it upon myself to find out what I could do before that time was up because I needed -- I wanted to know ahead of time what was going to happen." It is unclear to the Arbitrator from the Petitioner's cross exam testimony if the Respondent only would not be able to accommodate Petitioner in the light duty job she desired and requested, or if Respondent was unable to accommodate her restrictions at all at the time of her resignation. While she testified she resigned because she was unable to lift, she agreed that her resignation letter did not indicate this as a reason.

Petitioner testified that she worked 12 hour shifts, with an average of 10 patients per shift, but agreed she wasn't constantly lifting and moving patients. Her job also included feeding, dressing, vital signs, sitting with patients, etc. It depended on patient needs, and there was patient turnover. She agreed that she therefore might move all

of her assigned patients one day, and none of them on other days. She sometimes had to move beds and equipment.

On further cross exam, Petitioner testified her left shoulder pain started out of the blue in the spring of 2015, with no specific trauma, as she reported to Dr. Burge. She agreed her therapy notes referenced the "21 Day Fix", a video exercise program involving an upper body workout with weights. She would do them on average 5 days week, 30 min each workout, but denied injuring herself while exercising.

Currently she works at Heartland and also picks up night shifts at Wexford, where she passes medications at a prison. She will be a registered nurse in less than a month. As a telemetry technician at Heartland, she works 12 hour shifts, including answering phones, watching heart monitors and entering physician's orders. She does not see patients or move equipment. When she initially saw Brown, Petitioner had already left Respondent's employ and had started working at Heartland. She agreed that the pain diagram she completed for him on 9/29/15 indicated left shoulder pain, as opposed to either side of her neck or down the arms, but testified she did complain to him of neck pain. She did indicate to Dr. Mall in 2/5/16 that her pain was in the left arm, top of the shoulder and neck, and did note bilateral shoulder problems since 2015, testifying that there was some right shoulder pain, but worse on the left, and that she has not had any right shoulder problems. The pain diagram completed for Dr. Gornet in 2/16 noted stabbing pain and numbness in the upper back, which Petitioner agreed was a different than the one she completed for Dr. Brown in 2015.

Since her shoulder surgery, Petitioner has been released by Dr. Mall and she is currently only treating with Dr. Gornet right now, and he has allowed her to work unrestricted.

While there are references to bilateral complaints in some of her records, Petitioner testified she never received any right shoulder treatment, just the left. She has not injured her shoulders or neck in her current jobs, noting there is no heavy work in them. The 9/29/15 review of systems from Dr. Brown's intake form (Px6/Rx12) notes Petitioner indicated left shoulder pain, left neck pressure and occasional left hand tingling, which is consistent with what she told her physician, but agreed the left shoulder is mentioned multiple times. To her recall, Dr. Brown had mentioned a cervical MRI, and believed there was a recommendation for it in his records.

CONCLUSIONS OF LAW

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

The true issue in this case is not with regard to accident, but with regard to causation. The Respondent has stipulated that the Petitioner sustained a compensable accidental injury to the shoulder and provided proper notice of same. As such, there is a stipulated accident and notice. Respondent's argument relates to the argument that the initial mechanism of injury relates to only the shoulder, and that the Petitioner's initial complaints were directed only to the shoulder, and that therefore the Petitioner has failed to prove accident and notice with regard to an alleged cervical condition.

In the Arbitrator's view, this remains a causation issue, even given the specific arguments. We do not have two separate accidents: we have two separate conditions. It would be impossible for the Arbitrator to find accident

and notice of one body part and to deny same with regard to another body part when both arise out of the same accident. The proper realm of this dispute is in the area of causation.

Based on the stipulations of the parties, the Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of her employment on 8/18/15, and provided timely notice of same.

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

The Arbitrator finds that the Petitioner has failed to prove that any cervical condition of ill-being is causally related to her employment with Respondent. It doesn't make sense to the Arbitrator in this case that an annular tear was caused by the Petitioner's lifting at work, she then has no complaints of neck pain or headaches until after leaving her employment with Respondent, and then develops neck pain and headaches that are related to the annular tear.

As Dr. Gornet has testified to, in his opinion, annular tears can be symptomatic or asymptomatic. The simple fact that a person has an annular tear, in and of itself, does not indicate a symptomatic pathology. That is clear. Additionally, in this case, it is questionable to the Arbitrator whether the Petitioner truly has an annular tear at C5/6. While Dr. Ruyle testified that he was able to see an annular tear at that level when he re-reviewed the MRI films, his initial review did not see such annular tear, and this despite the fact he noted such a tear at a different cervical level. Dr. Bernardi also disputed the annular tear. While it is certainly possible one exists at C5/6 based on the testimony of Dr. Gornet and Dr. Ruyle, the totality of the evidence in this case would indicate this to be a very minor finding in the view of the Arbitrator, and certainly not such a finding that would lead to the conclusion that the Petitioner requires a significant surgery such as that proposed by Dr. Gornet.

Another statement that caught the Arbitrator's interest was Dr. Gornet's statement that the Petitioner's headaches "must" be coming from the cervical spine. In the Arbitrator's experience, just as Gornet testifies to overlap between the shoulder and neck, there are multiple possible causes of headaches. The fact that Petitioner has them in no way, in the Arbitrator's view, in and of itself pinpoints the cervical spine as the cause. Dr. Gornet in this case seems to ignore the fact that the Petitioner simply did not have the complaints he relies on at the time of the alleged accident date. While he also testifies that symptoms can evolve over time, symptoms can also occur over time. This young lady appears to have continued to perform the 21 Day Fix, for example, using weights after the accident date. It is just as possible that this activity resulted in her symptoms. Using a chain of events analysis, it just does not seem more likely than not that this claimant's neck and head symptoms are related to the accident at issue, i.e. the lifting, pushing and pulling of patients at the Respondent's facility, in the time around May 2015. The first indication of such complaints that the Arbitrator noted was in the December 2015 report of Dr. Brown, which was the first reference to the cervical spine by a physician. This is six months after the alleged accident date, and well after the Petitioner left the employ of the Respondent. Additionally, as Respondent's expert has pointed out, evidence exists which indicates Petitioner had headaches prior to the accident date.

The Arbitrator also is not comfortable with the fact that Dr. Gornet testifies to these overlap issues between the neck and the shoulder, and yet had already prescribed the cervical surgery before the shoulder surgery had already been completed. Again, this doesn't make sense to the Arbitrator. The only way this makes sense is if he had already determined at that point that the Petitioner had symptoms related to both the neck and the shoulder, which is difficult to understand when the shoulder had not yet been addressed, and given the shoulder films showed very clear, non-controversial evidence of pathology. When it comes to annular tears and their involvement in symptoms, the issue, as noted by Dr. Bernardi, is more controversial. When discussing this, Dr.

Gornet testified: ". . . the majority of symptoms are neck pain and headaches." This was untrue at the time he initially made the initial surgical recommendation, because at that time it was very clear that the Petitioner's key complaints referred to the left shoulder, in particular the AC joint itself.

Petitioner testified she initially complained of pain in the top of the left shoulder down her arm. The contemporaneous records when she first sought treatment support complaints in the left shoulder, but do not support complaints down the arm, and there was no numbness or weakness. She was diagnosed with shoulder joint pain. The Arbitrator also notes the Petitioner reported to Dr. Burge that she had been exercising 5 times per week, and the initial therapy records indicate this included the "21 Day Fix". Her history there noted goiter with head and neck swelling. No physician commented on this prior history, including Dr. Gornet in terms of how it may have influenced complaints of neck and head pain. Physical therapy also noted tightness in the neck muscles and upper trapezius. On 8/3/15, Petitioner reported glandular swelling in the neck to Dr. Burge.

Petitioner herself testified, in terms of Dr. Burge not examining her cervical spine, "she knew where my pain was." This in itself indicates the complaints were centered on the left shoulder.

On 11/13/15, Dr. Brown noted Petitioner specifically pointed to her AC joint as the location of her pain. The first real indication of complaints beyond the left shoulder was with Dr. Brown on 12/9/15, when Petitioner reporting worsening symptoms that included daily migraines, pain radiating from the base of the skull to the upper trapezius and shoulder area, and numbness and tingling of the bilateral hands with movement of the neck including flexion, extension and rotation. This was almost three months after leaving her employment with Respondent. Noting this could relate to the cervical spine, Dr. Brown noted Petitioner's symptomatic complaints were "spreading."

When Petitioner first saw Dr. Mall, she told him she had complaints of shoulder pain and cervical spine symptoms, and that her work duties caused her to have bilateral shoulder pain, left much greater than right, as well as radicular-type symptoms which were also left greater than right, in May 2015. Again, the contemporaneous records of Dr. Burge, as well as her initial accident report, do not support the Petitioner's report to Dr. Mall of anything beyond left shoulder complaints. Additionally, a shoulder injection performed by Dr. Mall was noted to have almost completely resolved her symptoms. While Dr. Mall noted that all of the symptoms were not resolved, including those that could be cervical, he did not specify which of these symptoms he was referring to.

On 3/2/16, Petitioner complained to Section 12 examiner Dr. Nogalsky that she had started to notice, over the past several weeks, some numbness on the right side more than the left around the thumbs, as well as some numbness in her index and middle fingers. Following shoulder surgery, Petitioner then complained that her neck pain had increased.

Based on the preponderance of the evidence, the Arbitrator finds that the Petitioner has failed to prove that any cervical condition if ill-being that may exist is causally related to the accident and/or her employment with the Respondent. Additionally, the Arbitrator has significant questions, again based on the preponderance of the evidence, as to whether the Petitioner even has any significant cervical condition of ill-being based on the objective evidence.

The Arbitrator wishes to note that both attorneys did an excellent job of presenting their respective cases in this matter.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings above, the Arbitrator further finds that the Petitioner is entitled to the medical expenses incurred to date, as contained in Px1.

While the Arbitrator has determined that the Petitioner has failed to prove that her cervical condition, if any, is causally related to the accident, it also was reasonable to work the Petitioner up on a cervical basis given the interaction noted by both Dr. Gornet and Dr. Bernardi between the neck and shoulder with regard o shoulder symptoms. However, at this point, the issue has been determined by the Arbitrator, and the Respondent is not liable for any further cervical treatment of the Petitioner. Further, there was no indication from Dr. Bernardi that the treatment Petitioner has received to date has been unreasonable or unnecessary, and the Arbitrator finds no evidence of unreasonable or unnecessary treatment to date. As such, Respondent is liable for same pursuant to Sections 8(a) and 8.2 of the Act. The Respondent is entitled to a credit for any awarded bills that were paid by Respondent prior to the hearing date, pursuant to Sections 8(a), 8(j) and 8.2 of the Act.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings regarding causation of the cervical spine, this issue is moot. However, the Arbitrator also finds that the surgical procedure itself, as recommended by Dr. Gornet, is not reasonable and necessary based on the evidence in this case. Dr. Bernardi's testimony was significantly more persuasive than that of Dr. Gornet in this case with regard to the reasonableness of the surgery. He credibly testified that the recommended procedure at this time remains off label peer the FDA, and that the objective findings do not support such a procedure. This was also verified by the testimony of Dr. Hachigian-Gould. The Arbitrator found the testimony of Dr. Hachigian-Gould to be very interesting in this case when compared to that of Dr. Gornet. While she agreed that the doctor was free to perform the cervical disc replacement procedure, there is currently a lack of consensus in the orthopedic community with regard to the procedure, and there is a lack of long-term outcome, peer-reviewed evidence-based studies to support the procedure. Dr. Gornet, on the other hand, consistently focuses on the studies he has been involved with, and which he indicates will be published at some point in the future, in support of performance of the procedure. While this in and of itself is not the sole determinant of the reasonableness and necessity of the procedure, it does seem clear to the Arbitrator that there is no consensus on the issue, and that this does tend to show that the procedure, at least at this point in time, may not be reasonable and necessary. Dr. Gornet, on the other hand, appears to rely significantly on research he himself has been involved in and his own results rather than the current standards and literature of the surgical spine community.

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

DEBORAH SILLMAN,

Petitioner,

vs.

NO: 10 WC 18749

CITY OF CHICAGO,

18IWCC0571

Respondent.

DECISION AND OPINION ON SECOND REMAND

This cause comes before the Commission pursuant to a second Remand Opinion and Order of the Circuit Court of Cook County, Law Division, Tax and Miscellaneous Remedies Section, entered October 14, 2016.

Petitioner previously appealed the June 18, 2013 §19(b) Decision of Arbitrator Kane finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on October 15, 2009, that Petitioner's current condition of ill-being is not casually related to the alleged accident and denying compensation. Relying on the opinions of Respondent's examiners, Dr. Wehner, an orthopedic and spine surgeon, Dr. Ghanayem, an orthopedic and spine surgeon, and Dr. Noren, a pain specialist, Arbitrator Kane found Petitioner had significant long-standing cervical, thoracic and lumbar spine chronic pain syndrome well-documented in treating records of Dr. Joseph and Chiropractor Regan from treatment from 2002 through October of 2009. The Arbitrator further found that that Dr. Joseph, Petitioner's treating physician, noted that on October 19, 2009, four (4) days after the alleged October 15, 2009 injury, Petitioner had severe worsening of her neck and upper back pain since her work-related injury on November 4, 2002, increasingly disabling and more severe even with less strenuous tasks. Dr. Joseph's office visit notes on October 19, 2009 failed to mention any other work-related injury other than Petitioner's prior work injury of November 4, 2002. The Arbitrator concluded Petitioner failed to prove she sustained a compensable accident on October 15, 2009, and that there was no causal connection between Petitioner's present condition of ill-being and the alleged accident, rendering all other issues moot.

On July 3, 2013 Petitioner filed a Petition for Review of the Arbitrator's decision, raising issues of accident, notice, causal connection, medical expenses, TTD, and penalties and fees, and arguing that Petitioner sustained an aggravation and acceleration of her pre-existing cervical and myofascial condition and a new injury to her lumbar spine on the date of accident while lifting a bag or mortar.

The Commission, in a July 14, 2014 Decision, unanimously affirmed and adopted the decision of the Arbitrator. Petitioner sought review of the Commission's Decision and Opinion on Review.

In a March 5, 2015 Order, the Circuit Court of Cook County remanded the decision of the Commission "for the purpose of weighing the evidence to determine whether the 2009 Accident aggravated Employee's preexisting condition." The Court stated that within the Commission's decision "the only reference to a preexisting injury in the analysis is contained in the first paragraph of page eleven (11) of the adopted decision stating '...[Employee's] pain on October 15, 2009 was a manifestation of her pre-existing illness...'" The Court further stated that "this sentence alone, though reasoned by the Commission, does not weigh the evidence as to Employee's argument that the 2009 Accident aggravated a preexisting injury. The Commission failed to both address Employee's claim that the 2009 Accident aggravated Employee's preexisting condition, and make a permissible inference on the matter."

Pursuant to the Court's March 5, 2015 Remand Order, the Commission further addressed the Petitioner's claim that her October 15, 2009 alleged accident aggravated her preexisting condition. First the Commission addressed the Court's statement that "the only reference to a preexisting injury in the analysis is contained in the first paragraph of page eleven (11) of the adopted decision stating '...[Employee's] pain on October 15, 2009 was a manifestation of her pre-existing illness...'"

A review of the Commission decision indicates numerous references to a preexisting injury analysis:

1) page 8, paragraph 1- "The Arbitrator finds that Petitioner failed to prove that she sustained a compensable accident and/or aggravation of her pre-existing condition on October 15, 2009;"
2) page 8, paragraph 2- "The following is the basis of the Arbitrator's opinion: 1) Petitioner had been treating for the same pain complaints since 2002; 2) there are no objective findings to support an accident or aggravation on October 15, 2009; and, 3) the opinions of Dr. Wehner, Dr. Ghanayem and Dr. Noren are more credible than those of Chiropractor Regan and Dr. Joseph;"
3) page 9, paragraph 4, "The Arbitrator finds that here are no objective findings to support an accident and/or aggravation of Petitioner's pre-existing condition on October 15, 2009;"
4) page 10, paragraph 4, "In a report dated October 19, 2009, Dr. Joseph indicated that Petitioner had severe worsening of her neck and upper back pain since her work-related injury on November 4, 2002. The doctor noted that Petitioner's pain was increasingly disabling and more severe with less strenuous tasks. There was no mention of any other work-related accident;"

5) page 10, paragraph 3, "The Arbitrator finds Dr. Ghanayem's opinion credible that Petitioner's subjective complaints of back pain were subjective, longstanding and pre-dated the alleged work injury of October 15, 2009. Although the doctor agreed that Petitioner had manifestations of her pain symptoms at work, he did not see any evidence of an injury...and concluded that there was 'no evidence of a distinct work injury causing structural changes to the integrity of her spine;'"
6) page 11, paragraph 1, "Dr. Wehner's diagnosis was chronic pain syndrome involving the cervical, thoracic and lumbar spine. The doctor opined that this was a pre-existing condition which was well-documented in the medical records by Chiropractor Regan and Dr. Joseph prior to the alleged accident of October 15, 2009; Petitioner's episode of back pain on October 15, 2009 was a manifestation of her pre-existing illness; there was no casual connection between Petitioner's condition of ill-being and the alleged work accident; work did not cause her chronic pain syndrome; and the alleged incident did not cause any change in Petitioner's condition."

So that the record is clear, the Commission noted it had also reviewed all of the evidence and concluded that the Decision of the Arbitrator was more than sufficient in its explanation of the Commission's view of the evidence. The Court's concerns were duly noted and considered.

Further, the Commission's Decision on first Remand noted though Petitioner may aver that the Decision of the Commission on Review does not do justice to her arguments relative to an aggravation of a pre-existing condition, there can be no doubt that the Commission considered and soundly rejected this argument. Petitioner's argument is undone by the records of her treating physician, Dr. Joseph. He did not attribute the problems about which the Petitioner complained to any work accident in 2009. His records note that this was a continuum of a myriad of problems that cascaded from 2002 until 2009.

The Commission trusted that the Court would recognize that the Commission had considered all of the Petitioner's arguments regarding an alleged accident and/or aggravation and rejected same. It was hoped that this Decision on (first) Remand would allay any concerns that the Court may have regarding the Commission's consideration of the record and adoption of the Arbitrator's Decision as its own.

Pursuant to the Court's Remand Order, and upon receipt of the record of proceedings in this matter, the Commission expressed its finding the Arbitrator properly weighed the evidence to determine whether the 2009 accident aggravated Petitioner's preexisting condition, and thereby affirmed and adopted the Arbitrator's decision, denying compensation based upon Petitioner's failure to prove she sustained an accidental injury arising out of and in the course of her employment on October 15, 2009, for the reasons stated therein and further expounded upon herein.

On Second Remand, the Circuit Court concluded that the Commission, on (first) remand, failed to address the Employee's (Petitioner's) claim the 2009 accident aggravated her preexisting condition and "make a permissible inference on the matter." Further, the Order states "that the Commission failed to follow the Court's directives and weigh the evidence in this matter and ignored the only objective evidence in this case, the MRI, without any explanation or basis."

With respect to the MRI, the Court found that Dr. Ghanayem's conclusion that he did not see any evidence of injury is unsupported by the record. The Court also held there is no foundation to an expert opinion where a doctor purposely omits an MRI, never reviews it or even considers the only objective medical information of the Employee. The Order goes on to state Dr. Ghanayem's belief that the Employee's complaints are subjective ignores the only objective evidence in this case finding Dr. Ghanayem's opinions are without foundation based upon his failure to even review the patient's MRI. The Court found Dr. Ghanayem's conclusions should not have been admitted as evidence because they are without any foundation based upon his failure to review the Petitioner's MRI. Thus, the Petitioner's preexisting condition was aggravated and that her on duty accident caused a new injury to her lower back.

The Circuit Court concluded the Commission further ignored the unrebutted evidence in this case and that the Commission's conclusions are against the manifest weight of the evidence. Therefore, the Circuit Court reversed the Commission's first Decision and Opinion on Remand and remanded the matter to the Commission for determination of the benefits the Employee shall receive finding Petitioner's preexisting condition was aggravated and that her on duty 2009 accident caused a new injury to her lower back.

Though the Commission does not subscribe to the Circuit Court's analysis of the record, it is bound to follow the Court's directive. Pursuant to the Court's Second Remand Order, and upon receipt of the record of proceedings in this matter, the Commission finds the Petitioner's preexisting condition was aggravated and that her on duty 2009 accident caused a new injury to her lower back, albeit in the form of a temporary fleeting aggravation of a pre-existing condition. The Commission having weighed the facts and opinions of the experts relies upon the facts, the Petitioner's medical records, Dr. Wehner's expert opinion, and what Dr. Wehner described as a "paucity of any type of radiologic or clinical finding" to arrive at this conclusion. The Commission also finds Petitioner lacks credibility. Petitioner reported to Dr. Wehner that her low back was not a problem prior to the specific injury in October 2009, however, Dr. Wehner noted that low back treatment was well documented in the medical records.

As instructed by the Circuit Court, the Commission does not rely upon Dr. Ghanayem's conclusions despite the fact those conclusions were formed after a clinical examination of the Petitioner and Dr. Ghanayem's review of the MRI report, and his opinion thereof: "By report, she does have spondylosis or degenerative changes." While the Commission recognizes any layperson can read an MRI report, the Commission would otherwise, in many, if not most, circumstances, defer to Dr. Ghanayem, well-known to this Commission as a prominent expert, to read and interpret the MRI report and look to the diagnostic, if necessary.

The Commission finds, however, the MRI report, in this instance, reflects exactly what is on the actual MRI diagnostic film, and no treating orthopedic doctor opined that there was anything of significance in the MRI report that would warrant treatment other than the treatment the Petitioner was already seeking at RIC for the seven years following her 2002 work injury.

The Commission, therefore, relies, in part, on the Petitioner's testimony and in part upon her treating doctors when finding that Petitioner sustained a temporary fleeting aggravation of her

pre-existing condition. After Petitioner's prior work accident in 2002, she was released to full-duty work in March 2003. (T, pp. 44, 45) Petitioner testified after her 2002 accident, Chiropractor Regan treated her for her lower back not for an "injury" but "maybe if I was sore one day when I went in." On the day after the subject incident, Petitioner went to see her chiropractor, Dr. Regan, with whom she had been treating with "twice a week," "sometimes maybe three" for seven years, from April 2003 up to and through the alleged second date of accident in October 2009. (T, p. 45)

Petitioner did not seek emergency treatment following the subject incident. Instead, Petitioner treated with the chiropractor, Dr. Regan, on Thursday and Friday following the subject incident and the following Monday saw Dr. Petra Joseph at the Rehabilitation Institute of Chicago (RIC) with whom she had also been treating for the same seven-year period between 2002 and 2009. (T, p. 31) Petitioner had also conceded it was possible Dr. Petra Joseph treated her for her lower back after the 2002 accident "if I was sore." (T, p. 49)

Four days after the subject incident, on October 19, 2009, when Petitioner saw Dr. Joseph at RIC, the office note described "Visit type" as "follow-up," four weeks after the last visit on 9/13/09. "Paperwork needed (for) future participation in Interdisciplinary Pain Program and Recommendation for Carpal Tunnel Release prior to Pain Program and Also plans to have foot surgery in near future." Petitioner's Chief Complaint did not include any low back complaint. The office visit notes documented:

> "Chronic worsening neck, upper back, shoulders radiating into back of head and turning into Migraine at times, pressure, pulsing associated with numbness left side forehead and body, needles in spine sensation, difficulty turning head to Left. ...aggravated by use of her arms...by stress, repetitive movement...has been treated regularly by chiropractor 3x a week, helps temporarily."

The Pain assessment also omitted any mention of low back pain; instead it noted: "Fibromyalgia tender points: bilateral lower cervical regions, right occiput, C7 spinous process, bilateral trapezius muscles, bilateral supraspinatus muscles." The Impression and Plan also omitted any reference to low back complaints at that visit which took place only four days after the subject incident. When asked if she had any lower back problems subsequent to October 15, 2009, Petitioner testified "I would not say never, but it was nothing that was permanent or bothered me after maybe a day or two. (T, p. 49) Petitioner testified during those seven years, between 2002 and 2009, Dr. Joseph had urged her to enroll in the pain management program at the Rehabilitation Institute of Chicago (RIC). (T, p. 22, 30)

Without ever undergoing physical therapy, only chiropractic treatment, Petitioner consulted Dr. Joseph Weistroffer at Orthopedic Surgery on August 4, 2010. Dr. Weistroffer conducted a physical examination and found a negative, normal motion from flexion to stand, spine musculature with good tone, no atrophy nor spasm, negative SLR and negative XSLR; normal gait and station, normal heel and toe walk, difficulty with tandem. His assessment was cervicalgia and lumbago. He ordered the lumbar spine MRI and referred the Petitioner to the neurology department at Northwestern/Dr. Jack Rozental. (Px12) The lumbar spine MRI was accomplished on August 11, 2010. (Px13) Petitioner returned to Dr. Rozental on October 5, 2010 with headache complaints. Dr. Rozental ordered a cervical spine MRI. On December 16, 2010,

nurse Sarah Jackson left a message for Petitioner to return her call. Nurse Jackson documented she would advise her Dr. Rozental reviewed (the) MRI of Cervical Spine and Carotid Doppler reports and both were within normal limits (WNL). On December 17, 2010 Nurse Jackson spoke with Petitioner who was concerned "that tests are normal but still having symptoms." A message was left on the patient's private voicemail on January 21, 2011 confirming that Dr. Rozenthal reviewed MRI and Doppler Study results. Both were WNL. (Px 14) There is no other mention of the lumbar spine MRI results or recommendations in reliance thereon.

Petitioner eventually enrolled in the RIC pain management program. Three years after the subject incident, on December 3, 2012, the RIC doctors, under the Spine-Pelvis section, noted: "lumbar range of motion limited due to conditioning, not pain, -cervical range of motion limited due to tightness, not to pain, She limits self" (Px12, pp. 57, 58)

The same records document Petitioner "does not take any prescription medication." The Impression and Plan state: "1. Chronic myofascial pain in cervical, upper thoracic, lumbar areas with tender points as listed above; 2. Sleep disorder; 3. Mood disorder/anxiety; 4. Poor posture; 5. Obesity." (Px12, pp. 57, 58) The Commission finds all these conditions to be pre-existing and therefore, that when the new injury occurred, it was fleeting and only temporarily aggravated her pre-existing conditions.

In rendering this Decision, the Commission also notes Petitioner's subjective pain complaints are unreliable as evidenced, in part, in the results of the Functional Capacity Evaluation (FCE) Petitioner participated in at RIC on January 24, 2013. The therapist's FCE report noted that the Petitioner demonstrated four (4) coefficients of variation above the permissible cut-points, suggestive of less than full effort during testing. Furthermore, the overall test findings, in combination with clinical observations suggested some minor inconsistency to the reliability/accuracy of Petitioner's subjective reports of pain/limitation. She was positive for 4/5 responses on the Waddell inappropriate symptoms questionnaire, indicating possible psychological distress and symptom magnification. The therapist found that with clinical testing Petitioner's subjective reports matched poorly with distraction-based objective findings. (Px22, pp. 1-2, 25)

The Commission finds the Petitioner's FCE report comports with Dr. Wehner's opinion report authored three years prior, the day prior to Petitioner's having the lumbar spine MRI, that Petitioner's reported pain complaints were fairly high despite a normal neurological examination. The Commission finds Petitioner lacks credibility, in part, based upon the FCE and, in part, based upon her denial to Dr. Wehner she had low back pain complaints prior to the subject incident which was well-documented in the records.

Based upon the Order of the Circuit Court, and as instructed to do so, the Commission finds that Petitioner sustained a new injury on October 15, 2009, one that was a temporary fleeting aggravation of her pre-existing condition, and further finds that there is no causal connection between her present condition of ill-being and the alleged work accident. The temporary fleeting aggravation, characterized by the Circuit Court as a new injury, caused no change in Petitioner's pre-existing condition.

18IWCC0571

Therefore, relying on Dr. Wehner's opinion that Petitioner's condition was pre-existing, Petitioner was at MMI and could return to work, full-duty without restriction, the Commission finds Petitioner suffered a temporary fleeting aggravation of a pre-existing condition, therefore, Petitioner is not entitled to compensation.

The Commission modifies the Arbitrator's Decision as stated herein and otherwise affirms and adopts the Arbitrator's decision, denying compensation based upon Petitioner's failure to prove she sustained more than a temporary fleeting aggravation of her pre-existing condition and no compensation is awarded for the accidental injury arising out of and in the course of her employment on October 15, 2009, for the reasons stated therein and further expounded upon herein.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 18, 2013, is hereby modified as stated herein and otherwise affirmed and adopted.

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

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

No bond is set by the Commission based upon the denial of compensation herein. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 19 2018
KWL/bsd
REM: 4/16/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maynard Hudson,
Petitioner,

vs.

NO: 15 WC 39586

18IWCC0572

State of Illinois,
Menard Correctional Center ,
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 Petitioner's issue of nature and extent of Petitioner's permanent partial disability, and Respondent's issues of accident, temporary total disability, permanent partial disability, notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 15, 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.

18IWCC0572

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

DATED: SEP 19 2018

o-09/11/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUDSON, MAYNARD
Employee/Petitioner

Case# **15WC039586**

18IWCC0572

MENARD CORRECTIONAL CENTER
Employer/Respondent

On 5/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 15 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MAYNARD HUDSON
Employee/Petitioner

v.

MENARD CORRECTIONAL CENTER
Employer/Respondent

Case # 15 WC 39586

Consolidated cases: _____

18IWCC0572

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **March 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **November 16, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$67,881.84**; the average weekly wage was **$1,305.42**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit under Section 8(j) of the Act for any awarded medical bills that were paid prior to the hearing date.

ORDER

Respondent shall pay the reasonable and necessary medical expenses for all causally related medical services contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for any awarded medical benefits that have been paid prior to hearing, 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 Sections 8(a) and 8(j) of the Act. Pursuant to stipulation of the parties, the Respondent may pay these expenses directly to the service providers.

Respondent shall pay Petitioner permanent partial disability benefits of **$755.22 per week**, the maximum allowable statutory rate, for **94.875 weeks**, because the injuries sustained caused the **7.5% loss of the right arm** and a **30% loss of the left arm**, as provided in Section 8(e) of the Act.

The Respondent is entitled to credit for a prior settlement between Petitioner and Respondent of **25% of the left arm** against the current award.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 18, 2017** through **March 15, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

18IWCC0572

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 8, 2017
Date

MAY 15 2017

STATEMENT OF FACTS

Petitioner testified that he was hired by Respondent on 6/22/09, and worked as a Correctional Officer (CO) until he was promoted to Correctional Sergeant 2 years and 3 months prior to hearing. Petitioner submitted a work history timeline (Px6), indicating he worked as a CO from 6/22/09 to 1/1/14, and subsequently worked a Correctional Sergeant. He testified that there is no real difference between the physical duties in these jobs with regard to the upper extremities. He has spent the majority of his time (97%) working at the Menard Maximum security facility, and about 85% of that time has been on the 7 a.m. to 3 p.m. day shift.

He testified that 80% of his time at Menard Maximum security has been as a Gallery Officer. In that position, he raps bars throughout a gallery once per shift. This involves using a 12" metal bar to strike each cell bar to verify the integrity of the bars. This would apply both to barred doors as well as solid steel doors, as some of the latter also have bars in them. He testified that this causes vibration in his upper extremity.

He testified he spent a little over a year in the Segregation unit. There, the cell doors are either solid metal or solid metal bars. The doors are heavy and slide open as opposed to being hinged, and they take force and use of grip to open them. Large Folger Adams keys are used to unlock and relock the cell doors.

There are chuckholes, used to transfer food and other items to and from inmates, in the cell doors that are locked with padlocks. These are unlocked with a smaller metal key. Petitioner testified that some of the cell doors and chuckholes can be particularly difficult to open due to age and how they are constructed. This requires extra grip and force, both in keying the locks and in opening the cell/chuckhole doors. Regardless, he has to work through this and complete the job. Petitioner testified that he also has to cuff and uncuff prisoners constantly throughout his shift. Petitioner testified that he has rapped thousands of bars and opened thousands of cell doors.

During "lockdowns", Petitioner testified that, in addition to the CO's regular duties, they also have to take on the full duties of feeding inmates. Every inmate is cuffed during those times. There's minimal movement of prisoners, but the rest of the normal duties still apply.

Petitioner reviewed the Respondent's "Demands of the Job" form (Px14), a Corvel Job Analysis (Px9) and video (Px10), and Respondent's "Post Description" (Px13), and testified that they accurately described his job duties. As to Px14, the "Demands of the Job", Petitioner testified that he agreed his job involved the following: frequent lifting or carrying up to 25 pounds, frequent pulling open of doors from 2.5 to 5 hours per shift, pulling open doors and chuckholes as needed, cuffing and uncuffing inmates, and wrist turning for one to two thirds of his shift. The Arbitrator notes that while the Petitioner's testimony regarding the document is applicable to this case, the document itself does not specify the job title it relates to, and appears to have been prepared for a worker other than the Petitioner. (Px14).

The CorVel Job Site Analysis of a Correctional Officer at Menard, dated 2/8/11, provides a narrative description of the job duties and classifies the strength demands of the job as frequent lifting and/or carrying up to 25 pounds, or up to 5 ½ hours per day. (Px9). According to this document, COs are required to frequently pull open doors from 2 ½ to 5 ½ hours per day, up to 66 % of the time or over 200 times per shift. This includes pulling open the steel cell doors, opening chuckhole doors as needed for dining during lockdown, and cuffing and uncuffing inmates. Wrist turning is required 34% to 66% of the time, 2 ½ to 5 hours per day, or up to 300 times per day. This work increases during lockdowns. (Px9).

Respondent's Post Description for Cellhouse Officers describes duties for Gallery, Escort, Crank, Door, Sanitation and Yard officers. For Gallery officers, the duties include patrolling galleries every 30 minutes, pulling cell doors twice to ensure cells are secure, performing inmate counts by looking in or opening the cells, removing inmates from cells for escort, monitoring all movement, searching cells prior to placement of inmates, checking all locks, doors and restraints to ensure they are in proper operational order and secured, shaking down workers and inmates, at least 2 cell shakedowns per day, keying inmates in and out of cells for all movement that is not a mass line movement, searching inmates entering and leaving the gallery, and securing grill and front doors. (Px13).

Petitioner also submitted a video of his job duties that was prepared by Respondent's vendor, CorVel. (Px10) The video depicts the demonstration of various CO job duties performed by a variety of them. Sample depictions included the armory, shakedown officer, bar rapping, double gate door, double gate walkway, opening cell doors, turning gallery cranks, receiving control house, control room, receiving door, shower door segregation, shower door, segregation unit, segregation door, chuckholes, double gate, and tower. Each area requires opening and closing multiple doors and using multiple keys, mostly Folger Adams keys. Bar rapping was simulated and the officer explained that, depending upon the shift, all open bars will be rapped to ensure that the bar is solid and that the inmates have not tampered with the cell doors. The officer held the baton with his right hand and struck approximately 60 bars on 1 cell. Bar rapping is conducted at the beginning of the 1st and 2nd shifts on the gallery where the CO is assigned. There are 55 cells per gallery. While some galleries have half solid doors and half open bars, COs could be assigned to more than one gallery shift per day. At one point, the videographer asked a CO if he always turned keys with the same hand, and the officer stated, "You learn to use both hands in here because you need about four of them." On another occasion, when the videographer requested a CO to demonstrate the unlocking maneuver in slow motion, the lock appeared to be stuck. He had to turn it multiple times to get it to work and explained that the locks were difficult to turn in slow motion. There appeared to be a mechanical problem, and the video was cut off at that point. (Px10)

Petitioner also prepared his own description of his job duties. (Px7). In addition to what he testified to, this document indicates activities including: lifting food trays and crates up to and down 10 stories; lifting and carrying laundry bags. It's unclear if this was the norm or if this was only during lockdown.

Petitioner testified that he does not have diabetes, gout, hypothyroid or rheumatoid arthritis. He is 5'10", 195 pounds and testified that he exercises, performing cardio and light weightlifting. Petitioner testified that he fishes and hunts quite often, including bow use. On cross exam, Petitioner agreed that he hunts and fishes as often as he can, both from boat and bank, and when he hunts waterfowl and deer, it can be all day long. He estimated approximately 5 hours per week is spent fishing and/or hunting, over maybe a couple of times a week, depending on work and weather.

Petitioner noticed numbness, weakness and cramping in his lower arms while performing his work duties. He testified he prepared an accident report for Respondent (Px15; Rx1) on 12/12/15, in which he alleges he developed *carpal* tunnel syndrome due to bar rapping and opening and closing cell doors.

Petitioner testified that he reviewed all of his medical records prior to the hearing, and agreed they were accurate. He initially sought treatment with Dr. Mall at his attorney's recommendation. He first underwent EMG/NCV testing with Dr. Phillips on 11/16/15. Dr. Phillips reported that testing revealed mild bilateral cubital tunnel, and was negative for carpal tunnel or cervical radiculopathy. (Px3).

Petitioner testified on cross examination that his attorney scheduled both the initial Phillips and Mall visits for him. He testified that the date of the EMG/NCV is what he based his date of accident on, i.e. the manifestation date, when he completed Px15. He indicated that he had never been diagnosed with carpal or cubital tunnel prior to this, and had no prior EMG/NCVs.

At his initial visit with Dr. Mall on 1/18/16, Petitioner noted a 6 to 12 month history of bilateral numbness and tingling in the ulnar digits, worse while sleeping and while performing work. The report states: "He states that the activities of opening and closing doors as well as turning keys at Menard Correctional Facility seem to worsen his symptoms. He has been working for the Illinois Department of Corrections for approximately seven years." Dr. Mall also noted Petitioner worked about 60 to 70 hours per week, including overtime, and that he hiked/fished/hunted approximately 2 to 3 hours per week. Following exam, Dr. Mall diagnosed bilateral cubital tunnel, though he wanted to review the EMG/NCV as well. He prescribed night bracing, alternating elbows each night. Dr. Mall noted Petitioner had no significant risk factors for cubital tunnel other than his job duties: "The doors and keys are quite heavy in this location. The doors often times stick and require push and pull." He opined that the work duties contributed to the development of cubital tunnel, noting this is supported by Petitioner's symptoms worsening during his regular job duties. When the night bracing didn't improve Petitioner's symptoms, on 2/16/16 Dr. Mall prescribed bilateral cubital tunnel surgeries. (Px4).

Petitioner was examined at Respondent's request on 4/12/16 by Dr. Sudekum pursuant to Section 12 of the Act. (Rx6). Petitioner testified that he completed intake documents for him and underwent a test where pads were put on his arms, and a machine sent shocks through his arms. He indicated this was performed by a nurse while Dr. Sudekum was not in the room. Following examination, review of medical records and review of various job descriptions, Dr. Sudekum indicated that Petitioner had complaints in the neck, back, upper and lower extremities, and the complaints were "widely dispersed and quite generalized". Noting he obtained NCV testing at his office that day, Dr. Sudekum indicated there was no objective evidence of cubital tunnel per the NCV, x-rays or physical examination. Noting he saw no evidence of a work related injury, Dr. Sudekum recommended a full evaluation from a general practitioner to review Petitioner's constellation of constitutional symptoms (listed in report) before any further determinations are made. He noted that

Petitioner's complaints in all four extremities could be spine related or due to a systemic condition. He also noted that Dr. Mall reported that night splints improved Petitioner's upper extremity symptoms significantly, and thus further conservative treatment was in order, though it would not be work related. (Rx6).

Dr. Mall performed right ulnar nerve decompression and transposition on 12/20/16. He noted significant ulnar nerve compression as he entered the flexor pronator mass distally. He was released to return to restricted duty as of 12/22/16. Left ulnar nerve decompression and transposition was performed on 1/5/17. Dr. Mall noted clear compression of the nerve at the entrance point to the flexor pronator mass. He was released to light duty as of 1/8/17. It appears Petitioner last saw Dr. Mall on 1/18/17, reporting "minimal complaints", and that he was back to full duty. Physical therapy and a full duty work release were prescribed, and Petitioner was to follow up in 4 weeks, but no subsequent report was entered into evidence. (Px5).

Petitioner testified that following each surgery he returned immediately to light duty work, which Respondent accommodated, for two weeks each time before returning to his regular duties, and therefore he had no lost time from work. Petitioner testified the surgeries did help, but he continues to have constant soreness, mainly with upper extremity activities, as well as stiffness, but his range of motion, numbness and tingling are significantly improved.

Dr. Mall testified via deposition on 3/25/16. (Px8). He testified that risk factors for cubital tunnel syndrome include having the elbow in a flexed position, as well as vibrational types of activities. He testified that he saw the Petitioner initially on 1/18/16 as an independent exam at the request of his attorney. The Petitioner reported numbness and tingling into his small and ring fingers bilaterally for six months to a year, worse at night and while at work. The symptoms would often times occur when opening and closing cell doors as well as turning keys and bar rapping at work. He reported working for the Respondent over seven years, full-time plus a lot of overtime. Dr. Mall testified that Petitioner's job duties were the major risk factor, noting he did not have any comorbid risk factors and minimal risk factors outside of the employment. Following positive examination findings for bilateral cubital tunnel, Dr. Mall obtained Dr. Phillips' EMG/NCV report, which confirmed the presence of bilateral cubital tunnel. Dr. Mall opined that at the very least the Petitioners job duties were aggravating if not causing the condition. He testified, as to Petitioner's daily work activities: "basically, these (cell) doors are heavy, they oftentimes stick and require a lot of pushing and pulling, a lot of elbow flexion activity. The bar rapping – it requires elbow flexion and vibration to the upper extremity." Dr. Mall testified that there could be a latency period between causative activities and the onset of the condition. He noted there is no specific set threshold with regard to the amount of required causative activities to be able to say they are causative. (Px8).

On cross examination, Dr. Mall testified that his understanding is that there is little difference between the duties of a CO versus a Correctional Sergeant other than a Sergeant had a little more paperwork to do and was supervising the other officers. He agreed that a person could have ulnar symptoms in their hand that come from the cervical spine, but that this was unlikely with Petitioner given he had symptoms with compression of the ulnar nerve at the elbow on examination. (Px8).

Dr. Mall agreed that the Petitioner reported he was working as a Correctional Sergeant when he saw him, and that different posts at Menard involve different work duties for COs. Other than bar rapping for 20 to 30 minutes over 40 to 60 cells at the start of a shift, Dr. Mall had no further detail regarding that job activity. He agreed that he could not say exactly which job posts the Petitioner performed on which days for the Respondent as a CO, and couldn't say exactly how many doors he would open or keys he would turn on any particular day. He testified that his opinion was based on a number of Petitioners activities, not just a single one. (Px8).

The deposition of Respondent's Section 12 examiner Dr. Sudekum was obtained and 9/6/16. (Rx7). In addition to things like age, diabetes and hypertension, he opined that activities that involve a lot of vibration or sustained elbow flexion can be causative of cubital tunnel. In agreement with Dr. Mall, Dr. Sudekum testified that the ulnar nerve can be compressed in multiple locations from the neck down to the wrist. The Petitioner reported an approximate one year history of numbness in tingling in his bilateral ring and little fingers. He indicated they developed about the same time he developed lower extremity neuropathic symptoms, involving his low back, that was particularly in his right leg, noting he had seen a chiropractor for same in the prior year and underwent adjustments and injections. The chiropractor also felt he had a cervical problem and recommended an MRI. The Petitioner also reported working out with weights 5 to 6 times a week, for an hour and a half each time. He also reported numbness in the bilateral upper and lower extremities to Dr. Phillips. Dr. Sudekum agreed he performed Neurometrix NCV testing at his office, and that he was present for at least part of the testing. While the testing revealed no evidence of upper extremity compression neuropathies, on exam the Petitioner had positive Tinel's and Phalen's findings at the bilateral elbows. (Rx7).

Based on his impression that Petitioner had several potential differential diagnoses, Dr. Sudekum opined that surgery for cubital tunnel was premature, even though the Petitioner could have cubital tunnel syndrome. He noted that Dr. Phillips also recommended further work up given multiple potential diagnoses. Noting he has visited Menard personally and watched many of the correctional officer activities, Dr. Sudekum opined that the duties in the MSU would not cause or contribute to carpal or cubital tunnel syndrome. With regard to maximum-security, he testified: "well, if a correctional officer, whether it be a Sergeant or a lower ranking correctional officer, were to perform sustained repetitive bar wrapping and/or having to forcibly open and close the cell doors on multiple repeated occasions, over the course of a shift, I felt that that type of activity could potentially serve to aggravate cubital tunnel syndrome." (Rx7).

On cross exam, Dr. Sudekum testified that he was not certain how much time the Petitioner spent working on a gallery, and agreed he indicated he rapped bars and worked overtime. He agreed that there were about 60 cells per gallery. He also agreed that on one of his tours of a gallery, an officer had trouble opening a lock. (Rx7).

Petitioner testified that he continues to work overtime as often as he can, estimating he has worked mostly voluntary overtime on average 12 to 16 per week over his years with Respondent. For relief he takes ibuprofen daily and performs stretches. He has hunted once but has not attempted to fish since his surgeries.

On cross examination, Petitioner testified he worked as a CO for about 5.5 years. His primary care physician is Dr. Pickett, and Petitioner testified he had not made complaints to him about his hands or arms. Petitioner testified that, while he initially saw his attorney in 10/15, and had his EMG in 11/15, he didn't report an accident to Respondent until 12/12/15 because he didn't know exactly what his diagnosis was at that time.

Petitioner testified he started working at the Maximum security unit in 8/09. He agreed he has also worked shifts at Medium security (MSU), which is a newer facility than Maximum security. In MSU, the keys used there are larger than a house key, but not as big as a Folger Adams. There is no bar rapping at MSU, and sometimes an electronic pod is used to open cell doors, but he testified that the doors there can still be difficult to open. At MSU, he worked as a CO in the last two months of 2014.

On cross exam, Petitioner testified he first became a Sergeant at the end of 12/15 on temporary assignment, and officially became a Sergeant on 3/15/16 in MSU. He did work after that as a Sergeant at times in Maximum security as well. He agreed that his job duties with regard to his arms was less physical as a Sergeant in terms of cell doors and bar rapping (See also Rx4), but that as a Sergeant you still could sometimes be assigned to work as a gallery officer.

Petitioner testified he did have some extended time off work in 2010 (Rx3) when he had surgery after being assaulted by several gang member inmates. He did make a workers' compensation claim and received a settlement (Rx9) which includes 25% of the left arm.

Respondent's counsel reviewed Petitioner's staff assignment history with him. (Rx2). Petitioner agreed he worked in Tower 20 (twice) and on perimeter patrol, both of which were performed at MSU. He agreed he had been assigned to various galleries and to Segregation at some point. However, in reviewing several of the listed staff assignments, Petitioner either denied ever having served on those assignments or noted that he only worked a few shifts despite the document reflecting more significant periods of assignment. Petitioner testified that despite specific assignments being listed, a staff assignment report may not reflect accurate information, as COs are moved around as needed. He testified that "absolutely zero" about the staff assignment report verified where he might be working any particular day.

This was essentially verified by the testimony of Major Monje, Respondent's representative. Staff like Petitioner are assigned basically based on department need, and those assignments can be completely different than what is listed on a staff assignment report for a CO. He did indicate that it was rare to have a staff assignment at MSU and to be moved to a post at Maximum security, and the CO would more likely be assigned to another MSU post. He testified that he works as a shift supervisor and has supervised the Petitioner directly. He testified that he considered the Petitioner to be a good employee, and, noting he was present for all of Petitioner's testimony, he had no disagreements with regard to the accuracy of the that testimony. He has been in corrections for over 20 years and has worked as a CO himself. He did agree that the work of a Sergeant was less physical than that of a CO. MSU was also less physical than Maximum security, with a newer building, hinged doors and more electronic opening of cells. On cross examination, Major Monje acknowledged that if Petitioner indicated he spent 80% of his work time working in a gallery, he had no way of showing that was not true.

All of his treatment relative to the claimed 11/16/15 accident has involved the elbows, not the wrists or hands, though he had symptoms in the hands. Petitioner's Exhibits 11 and 12 were rejected upon hearsay objection from Respondent. These documents relate to opinions of Dr. Sudekum in a different claimant's case versus Respondent. The Arbitrator notes that Dr. Sudekum's deposition (Rx7) was obtained in the case at bar, and any opinions of Dr. Sudekum that were indicated in Px11 and 12 were fair game for inquiry in Rx7.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the preponderance of the evidence supports the determination that the Petitioner sustained accidental injuries arising out of and in the course of is employment with the Respondent, and that the proper manifestation date in this case is 11/16/15.

When the issue is one of repetitive-type trauma in a workers' compensation claim, issues involving the "arising out of" aspect of accident and causation are necessarily intertwined.

In this case, the Arbitrator finds that the Petitioner worked as either a CO or a Correctional Sergeant throughout his employment with Respondent. He credibly testified that his job duties included relatively frequent locking/unlocking of cells and pulling and pushing cell doors open and closed.

Px14 referenced frequent lifting or carrying up to 25 pounds, frequent pulling open of doors from 2.5 to 5 hours per shift, pulling open doors and chuckholes as needed, cuffing and uncuffing inmates, and wrist turning for one to two thirds of his shift. According to Px9, COs are required to frequently pull open doors from 2 ½ to 5 ½ hours per day, up to 66 % of the time or over 200 times per shift. This includes pulling open the steel cell doors, opening chuckhole doors as needed for dining during lockdown, and cuffing and uncuffing inmates. Wrist turning is required 34% to 66% of the time, 2 ½ to 5 hours per day, or up to 300 times per day. This work increases during lockdowns.

It makes sense to the Arbitrator, based on Petitioner's testimony and the various job descriptions in evidence, as well as common sense, that much of this was likely performed with the elbows at least in partially flexed position, if not 90 degrees. The job video also made it clear that COs use both arms to perform their jobs, at least in part due to the difficulties of function in the locks and doors at the Menard Maximum security facility. Petitioner also testified that he performed bar rapping at least once per day, as if he was working a double shift, it appears to the Arbitrator this task could have been done twice in a day during such shifts.

Petitioner did perform a variety of duties while working as a CO. While the Respondent alleges that the Petitioner worked multiple different posts while employed at Menard besides the gallery, the Petitioner's testimony was clear that the vast majority of his time was spent on the gallery. The Respondent's production of Petitioner's staff assignment history (Rx2) was rendered relatively meaningless when it was indicated that, regardless of which posts the document indicates the Petitioner was assigned to on various dates, the Respondent would move COs around as needed per department need. Major Monje agreed that there was no way, via the use of the assignment history, that he would be able to verify where the Petitioner worked on any particular day. Petitioner testified that, as to several of the indicated posts in the assignment history, he either didn't work the post at all, or worked only one or two shifts on that post. This is a significant factor in this case as well, as it supports the idea that the Petitioner's testimony is the best evidence presented as to what he did on a daily basis.

Multiple pieces of evidence were presented which purport to describe the nature, frequency and force required with regard to a CO's job duties. The Arbitrator believes these documents and video, along with the Petitioner's testimony, describe job duties that were performed on a semi-repetitive basis, and that these same job duties often required a significant amount of force given the condition of the locks and cell doors at the Menard Maximum security facility. The Arbitrator believes that the frequency and force required in the job constituted sufficient evidence of job activities that were both frequent and forceful enough to involve an increased risk of injury arising out of the employment. In this regard, the Arbitrator notes this is consistent with the Appellate Court's findings in *Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 195, 530 N.E.2d 1135, 1142 (1988). This is further supported by daily bar rapping, which resulted in vibration to the upper extremity. If the Petitioner was working a double shift, the Arbitrator would assume that he may even have performed bar rapping more than once per day. Thus, the Arbitrator finds that the Petitioner sustained accidental injury to the bilateral elbows involving compression of the ulnar nerves which arose out of and in the course of his employment with Respondent.

The Arbitrator also notes that the evidence indicates that the Petitioner worked about 60 to 70 hours per week. The Arbitrator believes that this is a significant factor in the determination of compensability in this case, as it supports the fact that the Petitioner performed these duties significantly more often than he would have had been working 40 hour

weeks. The Petitioner's testimony is supported by Major Monje, who indicated he did not disagree with Petitioner's testimony, as well as the records of Dr. Mall. The Respondent has offered no rebuttal in this regard.

The Arbitrator further finds that the Petitioner has also shown by the preponderance of the evidence that his bilateral cubital tunnel syndrome is causally related to the noted work duties. The standard of proof regarding causation in the State of Illinois is that an accident might or could have been a competent cause of a particular injury. A claimant need not show that the work activities were the primary or most significant cause. The work must simply be a causative factor.

Here, both Dr. Mall and Dr. Sudekum concurred that the CO duties involving bar rapping and the opening and closing of difficult heavy cell doors could cause or aggravate cubital tunnel. Dr. Mall indicated that he could not provide a specific "breaking point", i.e. a specific period of time such duties would need to be performed in order to determine they were causally related to the condition. In this regard, the Arbitrator found two facts in particular pushed this case in favor of the Petitioner. First, his testimony as to where he worked and when, i.e. as a gallery officer, was essentially unrebutted. As noted, the staff assignment report provides virtually no accurate information in this regard, and the Petitioner's testimony that he worked very little if any of some of his listed posts was unrebutted by Major Monje. Secondly, the Petitioner worked a significant number of overtime hours, and therefore his shifts appear to have often been worked significantly beyond 40 hours per week. Additionally, as noted, the Arbitrator specifically notes that in viewing the Petitioner testify, he appeared to be a very credible witness.

There is an issue as to the fact the Petitioner had been working as a Sergeant by the time he claims his symptoms onset. However, the Arbitrator believes this period of time was only a few months, based on the evidence of onset and when he started the Sergeant's job, and the Petitioner testified, again with no dispute from Major Monje, that he would still be assigned CO gallery duties as a Sergeant.

Another issue arose based on the report pf Dr. Phillips and the report and testimony of Dr. Sudekum with regard to whether the Petitioner even had cubital tunnel. The Arbitrator thinks the significant preponderance of the evidence indicated, without ruling out any other possible diagnoses, that the Petitioner had bilateral cubital tunnel. This is supported by the EMG/NCV findings of Dr. Phillips, his diagnosis of cubital tunnel despite his indication that there might be other contributing conditions, and the exam and diagnosis made by Dr. Mall. While Dr. Sudekum questioned the diagnosis, he himself testified that most often the symptoms from cubital tunnel involve complains of numbness in tingling in the ring and little fingers, typically worse at night or when the elbow is completely immobile. This appears to be exactly what the Petitioner complained of to him. Dr. Sudekum also specifically noted that, on his exam, Petitioner had positive Tinel's and Phalen's testing of the ulnar nerve *at the elbow*. The Arbitrator also finds that the standard EMG/NCV testing performed by Dr. Phillips, in this case, is more credible than the Neurometrix NCV testing by Dr. Sudekum, given all of the other surrounding facts.

With regard to the issue Dr. Sudekum indicated regarding complaints in all four extremities, the Arbitrator notes that Dr. Mall's surgical reports reference clear evidence of ulnar compression at the elbows. This certainly supports the diagnosis of ulnar neuropathy. While it is possible that a systemic problem could be causing or contributing to the compression, the key issue for the Petitioner is whether there is a preponderance of evidence which supports the fact that the job duties were a causative factor in the condition. The Arbitrator finds that the preponderance of the evidence indicates that they were.

The Arbitrator believes the greater weight of the evidence supports the finding that the Petitioner's work duties were at least a contributing factor in his development of bilateral cubital tunnel conditions.

The Arbitrator also wishes to note that the manifestation date selected by Petitioner appears to be appropriate in this case. Of note, he had symptoms in his hands, and his initial reports even indicated he thought he had carpal tunnel syndrome, not cubital tunnel. Thus, it is fair to say that the manifestation date is when the cubital conditions were first diagnosed by Dr. Phillips.

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

Given the findings above with regard to accident and causation, as well as manifestation date, the Petitioner provided notice to the Respondent (on 12/12/15) within the required 45 days.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner submitted the medical expenses that are alleged to be causally related to the 11/16/15 accident as Petitioner's Exhibit 1. Based on the Arbitrator's findings above, and the Arbitrator's finding that the treatment itself was reasonable and necessary pursuant to Section 8(a) of the Act, the Arbitrator finds that Petitioner is entitled to, and Respondent is liable for, the medical expenses contained in Px1.

The parties stipulated that the Respondent may submit payment for any awarded medical expenses directly to the provider(s). Respondent is also entitled to credit for any of the awarded medical expenses that were paid prior to the hearing via workers' compensation or via group health pursuant to Section 8(j). With regard to any such credits to Respondent, the Respondent shall hold the Petitioner safe and harmless from any attempts for reimbursement.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No

> single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial impairment rating was submitted into evidence by either party. Therefore, this factor carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Correctional Sergeant at the time of the accident, and he has since been able to return to this same position following is bilateral surgeries. While he still has to use his hands to do the same type of work he did before, the evidence makes it clear that he has to do it less often than he did as a CO. This factor weighs in favor of a lesser degree of permanency.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 33 years old at the time of the accident. Neither party has submitted evidence in support of how the Petitioner's age may impact is level of permanency. As such, this factor carries no weight.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there was no evidence presented indicating the Petitioner has suffered a diminution in his ability to earn wages in the future. He had a generally good result from surgery. This factor weighs in favor of a lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes, again, that the Petitioner was credible in his testimony, and the evidence of any ongoing disability is consistent with the medical records. He testified

It appears Petitioner last saw Dr. Mall on 1/18/17, reporting "minimal complaints", and that he was back to full duty. Physical therapy and a full duty work release were prescribed, and Petitioner was to follow up in 4 weeks, but no subsequent report was entered into evidence. (Px5).

Petitioner testified that following each surgery he returned immediately to light duty work, which Respondent accommodated, for two weeks each time before returning to his regular duties, and therefore he had no lost time from work. Petitioner testified the surgeries did help, but he continues to have constant soreness, mainly with upper extremity activities, as well as stiffness, but his range of motion, numbness and tingling are significantly improved.

Based on the above factors, the record taken as a whole, and the value of awards in similar claims before the Commission, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of use of the right arm, and 30% loss of use of the left arm, pursuant to §8(e) of the Act.

While there is little difference between the Petitioner's right and left arms in terms of permanent partial disability with regard to cubital tunnel, the Respondent has previously agreed with Petitioner that he sustained the loss of use of 25% of the left arm in a prior claim. Considering this preexisting loss along with the Arbitrator's evaluation of the current loss, the Arbitrator finds that this results in a total loss of use of 30% of the left arm. The Respondent is entitled to credit against this award for the prior 25% of the left arm settlement (see Rx9), resulting in a net award of 5% of the left arm.

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

Sha-Ree Swallers,
Petitioner,

vs. No: 14 WC 15853

18IWCC0573

State of Illinois,
Chester Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

A Petition for Review under §19(b) having been filed timely by Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical expenses, prospective medical expenses, and being advised of the facts and law, affirms 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 on April 20, 2017, is hereby affirmed and adopted.

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

18IWCC0573

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

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

DATED: SEP 19 2018

Joshua D. Luskin

Charles J DeVriendt

L. Elizabeth Coppoletti

o-09/11/18
jdl/wj
68

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

SWALLERS, SHA-REE
Employee/Petitioner

Case# **14WC015853**

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

18IWCC0573

On 4/20/2017, 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 0.94% 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:

2924 HARRIS AND JONES
KURT HARRIS
PO BOX 412
DU QOIN, IL 62832

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

APR 20 2017



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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sha-Ree Swaller
Employee/Petitioner

v.

Chester Mental Health Center
Employer/Respondent

Case # 14 WC 15853

Consolidated cases: N/A

18IWCC0573

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **December 28, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,048.68**; the average weekly wage was **$1,347.09**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$50,678.50** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that her current condition of ill-being in the cervical spine is causally related to the accident of December 28, 2013, Petitioner's request for prospective medical treatment to the cervical spine as recommended by Dr. Gornet is hereby denied.

Respondent shall pay for medical services **rendered up to February 26, 2015 as well as the EMG/nerve conduction study recommended by Dr. Matz,** 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 February 26, 2015 as well as the EMG/nerve conduction study recommended by Dr. Matz,** directly to the providers. Respondent shall pay any unpaid, related medical expenses **for treatment rendered up to February 26, 2015 as well as the EMG/nerve conduction study recommended by Dr. Matz,** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall be given a credit of **$50,678.50** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

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.

18IWCC0573

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. Gore-Gillman

Signature of Arbitrator

4/18/17

Date

ICArbDec19(b)

APR 20 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(B) ARBITRATION DECISION

Sha-Ree Swallers
Employee/Petitioner

Case # 14 WC 15853

v.

Consolidated cases: N/A

Chester Mental Health Center
Employer/Respondent

18IWCC0573

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she currently resides in Johnston City and that on December 28 2013, she was employed by Respondent. She testified that she has worked for Respondent for nearly 6 years. She testified that outside of this accident she has had other injuries at Respondent and has received medical treatment for the other claims, but no permanency settlements or awards.

Petitioner testified that her job title is that of Security Therapy Aide I. She testified that at the time of the accident, she was sitting at a table finishing paperwork, that there was a wall behind her and that her partner was standing to her right. She testified that a patient was coming at her from her left with the intent to attack, and that when she saw the patient getting close she tried to turn to her left. She testified that her partner was coming over from the top of her shoulders so she was "sandwiched" between the two individuals. She testified that the patient punched her in the mouth, and that she and her partner tried to push his hands away to deflect him from swinging at her and that he grabbed her around the throat. She testified that she tried to move his arms away from her throat, but was still "sandwiched" between the two men. She testified that she was able to get the patient to release his grip around her throat, but that he threw another punch and hit her under her left jaw. She testified that she was not sure if she lost consciousness, but remembered waking up from being on the floor.

Petitioner testified that when she came to, she saw another patient had her attacker around the neck and was pulling him backwards. She testified that after she regained consciousness, her mouth and nose were hurt and bleeding and that her throat was burning. She testified that she was able to get up and help her partner finish restraining the patient. She testified that they all fell to floor and that was when he fell on top of her hand. She testified that her right hand and wrist was "smashed" between the patient and the concrete floor. She testified that after the altercation was over, she hurt everywhere pretty much from head to toe. She testified that the majority of the pain was coming from her right hand and wrist and also in the neck and shoulder area.

Petitioner testified that she sought treatment at Memorial Hospital in Chester on the day of the altercation. She testified that she was then referred to her primary care physician, Dr. Riley at DuQuoin Rea Clinic. She testified that she saw Dr. Riley on January 3, 2014 because of the holidays. She testified that following his exam, Dr. Riley referred her for further care to Occupational Performance and Rehab in Marion. She testified that Dr. Riley referred her for chiropractic care, and that she saw Dr. Cochran at Tri County Chiropractic. She testified that she first saw Dr. Cochran on March 17, 2014 and that during this time, she was working light duty. She testified that while she was working light duty, the work Respondent was having her do was affecting her symptoms. She testified that she would be shredding

paper and that she would have to bend over to pick up the papers and pull out staples and paper clips, and that the sheer weight of the objects and repetitive motion would aggravate her symptoms. She testified that her hand was in a brace, and that she had to use her left side a lot more to compensate for her right hand. She testified that both of her arms, shoulders and neck hurt, and that she would get frequent headaches.

Petitioner testified that Dr. Cochran took her back off work and referred her for a cervical MRI. She testified that the first MRI was done at Cedar Court Imaging in Carbondale. She testified that following the MRI, she was seen in emergency room at Heartland Regional Medical Center on May 9, 2014 because her medications were not helping that day. She testified that her husband thought she should try to get into the hot tub as the heat and jets would often help alleviate some of the tension in her shoulder area. She testified that on that day, it did not help and made her pain worse and that she could not get comfortable or alleviate the pain. She testified that as she was getting out of the hot tub, she was in so much pain that it was starting to effect on her breathing and motor skills and that she felt light-headed and needed assistance to get out and make it to the couch.

Petitioner testified that she continued to treat with the chiropractor and that she was referred to a spine specialist, Dr. Gornet. She testified that she first saw him on July 28, 2014. She testified that following the exam, Dr. Gornet referred her to Dr. Tanaka, a shoulder specialist. She testified that she presented to Dr. Tanaka's office at Regeneration Orthopedics on August 6, 2014 and that he referred her for an MRI of her right shoulder which was performed on August 6th. She testified that on September 21, 2014, she went to SIH Prompt Care/Center for Medical Carts in Carbondale and that her symptoms included pain from her neck down to her lower back. She testified that her activity level affects her pain level and that if she uses her right arm, she has symptoms including pain and tingling in right shoulder and neck.

Petitioner testified that on September 29, 2014, she underwent a cervical MRI at MRI Partners of Chesterfield. She testified that Dr. Gornet referred her for injections, which were performed by Dr. Boutwell in St. Louis. She testified that the injections were performed on October 13, 2014 and October 27, 2014. She testified that the second injection was more painful than the first, and that they did not give her any pain relief. She testified that following the injections, she was referred to CT Partners of Chesterfield for a CT scan of the cervical spine and that she underwent the imaging on February 9, 2015. She testified that on February 26, 2015, she participated in an IME with Dr. Matz at the request of her employer, and that following the IME she underwent an EMG/nerve conduction study with Dr. Phillips.

Petitioner testified that Dr. Gornet has recommended surgery and that she wants to undergo it. She testified that her neck and cervical spine symptoms on the date of arbitration included her pain getting worse from having to sit in the chair and turn her head. She testified that her pain seemed to radiate depending on her activity level, and that if she used her right side more then she would have more pain on the right side than the left. She testified that she always has some pain level and symptoms no matter what she doing, even if she is simply lying on the couch.

Petitioner testified that her weekly temporary total disability benefits were terminated following the IME with Dr. Matz, and that her benefits were terminated on July 29, 2016.

On cross examination, Petitioner agreed that she had received temporary total disability benefits in full up until the time at which they were terminated. She agreed that she started receiving temporary total disability benefits starting July 3, 2015.

On cross examination, Petitioner agreed that when she saw Dr. Gornet in July of 2014, she told him that she had neck pain with headaches with radiation down the right arm. When asked if she told Dr. Gornet in July of 2014 that she was having pain in the left side of her neck or down her left arm,

Petitioner testified that she believed that she told him that pain was generally in her neck and shoulder area, and that depending on activity, it affected both of her arms. She testified that at that point, she was still going through occupational therapy for her right wrist and that the pain was more prominent on her right side. She testified that she still has issues with her wrist, and that with repetitive motions it feels like she has internal swelling and that she has reduced grip function. When asked if she has any complaints with right shoulder, Petitioner responded that the trigger point injection given to her by Dr. Tanaka relieved a lot of the range of motion issues that she had with her shoulder, and that today the pain is more of an aching, burning pain. She testified that Dr. Tanaka said she could do exercises to get the range of motion back in her shoulder.

On cross examination, Petitioner agreed that after the accident she felt pain in her right hand, neck and right shoulder. She testified that when she went to Chester Memorial Hospital, she told them she was hurting in those areas. She testified that she did not remember if she was asked if she lost consciousness. She denied telling the triage nurse at Chester Memorial Hospital that she did not have any injury to her neck and testified that she had bloody scratches that were plainly visible. She testified that she did not recall whether or not she lost consciousness and that she just remembered a "black-out period." She agreed that the emergency room physician diagnosed her with a hand sprain and said to follow up with her family physician.

On cross examination, Petitioner agreed that she saw her primary care physician, Dr. Riley, on January 3, 2014 and testified that she told him about her neck injury. She agreed that when she went back to see Dr. Riley on January 13, 2014, she reported to him that her neck pain was not going away. When asked about the discrepancy between the contents of the note and what she told Dr. Riley about her neck pain, Petitioner testified that she was told that the records were switched to new computer system and that a lot of doctor's notes were deleted and changed.

On cross examination, Petitioner agreed that when she saw Dr. Travis at the Center for Medical Arts, it was about two months after she saw Dr. Gornet. She agreed that Dr. Travis noted a history of neck injury at work and chronic left-sided neck pain since then. When asked if she was having right-sided neck pain in September of 2014, Petitioner responded that she had neck pain that was generalized in the neck and that it depended on the activity that she was doing. She testified that if she used the left side more like when her hand was in the brace, she had more prominent pain on her left side at that time.

On cross examination, Petitioner agreed that since December of 2013, she has had falls but did not know the dates. She testified that she fell at her house once and that another time she fell in the parking lot at work in the winter when there was ice on the ground. She testified that when she fell at work, it was sometime in the winter of 2014-2015 and that the fall at her house occurred around the same time. She testified that the fall referenced in Dr. Travis' note about falling off a stepstool resulted in back pain. She testified that she told Dr. Gornet, Dr. Cochran and her therapist about the fall at her house.

On redirect, Petitioner testified that when she presented to her physicians she tried to be thorough and direct with her responses. She testified that she was not the individual documenting her responses in the medical records.

The Medical Attachment was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of Memorial Hospital of Chester were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on December 28, 2013, at which time it was noted that she was involved in an altercation with a resident at work. It was noted that Petitioner stated that a resident grabbed her neck and hit her and pushed her down, and that she denied injury to the neck and voiced right hand pain. It was noted that Petitioner stated that she landed on her right hand and

voiced right pointer finger and right thumb pain. The interpretive report for x-rays of the right hand performed on December 28, 2013 noted that the films were interpreted as revealing no radiographic evidence to suggest acute bony fracture. The primary impression was noted to be that of a hand sprain. Petitioner was discharged home. (PX2).

The medical records of Christopher Rural Health – REA Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on January 3, 2014 with complaints of musculoskeletal pain. It was noted that the duration was six days, the location was the right wrist and that the pain radiated to the fingers. It was noted that there was an injury during which Petitioner was attacked by a patient at work. It was noted that Petitioner went to Chester ER and was told she had a sprain, and that she fell forward. It was noted that Petitioner was also complaining of a knot on the left side of her face and left shoulder pain. The assessment was noted to be that of a soft issue injury of the hand, and Petitioner was referred to occupational therapy. Petitioner was also given a note to return to light duty on January 4, 2014. At the time of the January 13, 2014 visit, Petitioner was seen in follow-up for her hand injury. It was noted that Petitioner had not yet started any therapy. The assessment was noted to be that of soft tissue injury of the hand and neck pain. It was noted that Petitioner had an overuse strain secondary to repetitive motions with Petitioner's non-dominant hand and that stretching exercises were reviewed. Petitioner was also advised that she needed to start occupational therapy and was given a home exercise program for hand range of motion. Petitioner was instructed to continue working light duty. (PX3).

The records of Christopher Rural Health – REA Clinic reflect that Petitioner was seen on January 29, 2014 for follow-up on her right wrist. It was noted that Petitioner was going to Marion to Occupational Performance Rehab for therapy three times per week, and that she was using ultrasound, laser and ice to get the inflammation out. The assessment was noted to be that of soft tissue injury of the hand and neck pain. Petitioner was instructed to follow up in two weeks. At the time of the February 12, 2014 visit, it was noted that Petitioner had been wearing a brace and was still going to therapy. It was noted that Petitioner had a "test" on the 24th to see if she was able to go back to full duty. The assessment was noted to be that of soft tissue injury of the hand. Petitioner was instructed to continue therapy and continue light duty. A work slip was issued on February 21, 2014, indicating that Petitioner was excused for two days (February 21 and February 22) and could return to work on February 23, 2014 with no restrictions. (PX3).

The records of Christopher Rural Health – REA Clinic reflect that Petitioner was seen on February 26, 2014 for musculoskeletal pain. It was noted that Petitioner's problem was improving, that the location was in the right hand, that the pain was aggravated by lifting and that the pain was relieved by physical therapy. The assessment was noted to be that of work-related injury and soft tissue injury of the hand. Petitioner was instructed to continue therapy and light duty and return in two weeks. At the time of the March 12, 2014 visit, it was noted that Petitioner was still going to therapy for her right hand injury and that she had made improvement. It was noted that Petitioner wanted to go back to work without restrictions but felt like she needed to be 100% since her hands were her defense mechanisms. It was noted that Petitioner reported pain still to the last two digits on the right hand that radiated to the elbow, and that her therapist mentioned that she may need to see a chiropractor. The assessment was noted to be that of work-related injury and soft tissue injury of the hand. It was noted that Petitioner was slow with making progress, that she was encouraged to continue therapy and that she could consult a chiropractor for evaluation and treatment. It was noted that Petitioner was to continue light duty until her next appointment. (PX3).

The records of Christopher Rural Health – REA Clinic reflect that Petitioner was seen on March 26, 2014, at which time it was noted that she had been seeing the chiropractor three times a week and had x-rays done at the chiropractor's office. It was noted that Petitioner was still doing light duty at work

with shredding papers and filing. The assessment was noted to be that of soft tissue injury of the hand and work-related injury. It was noted that Petitioner had slow improvement and had had benefit from occupational therapy and chiropractic care. It was noted that Petitioner's participating in repetitive activities during light duty at work appeared to be exacerbating her symptoms and that it was recommended that she not work for two weeks. A work note was issued on March 26, 2014, indicating that Petitioner was to be excused for two weeks and that she could return to work light duty on April 12, 2014 with restrictions of no lifting over 5 pounds or repetitive movements. (PX3).

The records of Christopher Rural Health – REA Clinic reflect that Petitioner was seen on October 3, 2014, at which time it was noted that she stated her neck pain, which was secondary to a right wrist injury at work, had led to headaches that started in the back of her head and radiated toward the front. It was noted that Petitioner stated sometimes she could work through them and that at other times she had to call in to work. It was noted that Petitioner stated the pain could be miserable at times and that she was seeing a spinal surgeon for her neck condition. The assessment was noted to be that of neck pain and tension headache related to neck pain. At the time of the October 31, 2014 visit, it was noted that Petitioner stated that her tension headaches had greatly improved on Propranolol, that she stated that she could easily tell the headaches were linked to her neck pain and that she stated that when they came on, they were much more manageable. It was noted that Petitioner was to see her neck specialist on December 1st and that otherwise her neck pain was stable. The assessment was noted to be that of neck pain and tension headache. (PX3).

The records of Christopher Rural Health – REA Clinic reflect that Petitioner was seen on June 25, 2015, at which time it was noted that she needed a referral for an EMG. It was noted that Petitioner stated she continued with the specialists she had been referred to for her workers' compensation case, and that one of her doctors believed her right hand numbness was likely a nerve problem and would like an EMG performed. It was noted that Petitioner stated her headaches remained well controlled and that her neck stiffness and pain were about the same but reasonably controlled with her current medications. The assessment was noted to be that of numbness and tingling in the right hand, neck pain and tension headache. Petitioner was ordered to undergo an EMG which may also reflect nerve root pain from the job site occurrence. (PX3).

The records of Christopher Rural Health – REA Clinic reflect that Petitioner was seen on September 25, 2015, for a 3-month follow up of her injury. It was noted that Petitioner reported that her spinal surgeon was still recommending that neck surgery be done after her injury of her neck and right hand in December of 2013. It was noted that Petitioner stated that her headaches were reasonably controlled and that she continued to see her endocrinologist for her hypothyroidism. It was noted that Petitioner stated that she had some numbness around her elbow and forearm when she bent her arm in a particular way, and that she stated that for the most part she was doing well and may have paperwork to be filled out in the future. The assessment was noted to be that of neck pain and injury of the right hand. (PX3).

The medical records of Occupational Performance Rehab were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner underwent a Patient Evaluation on January 28, 2014, at which time the mechanism of injury was noted to be that of her having been attacked by a patient, that she went to restrain the patient and that as they were going to the ground, her right wrist rolled under. It was noted that Petitioner noted that all of her and the patient's weight rolled on her right upper extremity causing an immediate onset of pain. It was noted that Petitioner noted that one of the tasks that she was performing while on work duty was shredding papers which exacerbated her symptoms. The records reflect that Petitioner underwent therapy for the timeframe of January 28, 2014 through April 10, 2014 at which time the Discharge Summary was issued. (PX4).

The records of Occupational Performance Rehab reflect that at the time of the February 3, 2014 visit, it was noted that Petitioner reported that she slipped and fell getting out of her car the day before and had items in her left hand, and that she attempted to catch herself with her right upper extremity which had exacerbated her right wrist pain somewhat. At the time of the March 10, 2014 visit, it was noted that Petitioner had undergone 18 skilled occupational therapy treatment sessions from January 28, 2014 through March 10, 2014 and that she had made progress over the course of care with improved functional use of her right upper extremity noted. It was noted that despite progress, Petitioner continued to present with functional limitations that limited her ability to perform all job demands and return to work full duty at that time. At the time of the March 13, 2014 visit, Petitioner reported increased pain and soreness which she felt was attributed to an increased amount of shredding of paper at work. At the time of the March 17, 2014 visit, it was noted that Petitioner reported that she was going to the chiropractor to assist with neck pain and tightness, and that she noted she continued to feel the exacerbation of symptoms to the cervical region were effecting her abilities to grip and have full use of her upper extremities. At the time of the March 19, 2014 visit, it was noted that Petitioner reported she felt that the chiropractor was going to help her with decreasing the numbness and tingling in her right hand due to her cervical pain/issues. At the time of the March 20, 2014 visit, it was noted that over the course of care Petitioner had made significant progress and that her functional progress note indicated that she met all job demands required to return to work. (PX4).

The medical records of Tri-County Chiropractic Centre were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on March 17, 2014 for a chief complaint of neck/shoulder pain as well as right wrist/hand pain. It was noted that Petitioner had neck pain, bad headaches, neck tightness/stiffness and occasional numbness and tingling into the right hand. It was noted that Petitioner reported that her neck symptoms had definitely worsened with time and that it now seemed to hurt on the left side. It was noted that Petitioner initially thought she was just sore and that her scratches hurt, but with time her pain had worsened. It was noted that Petitioner had first noticed this on December 28, 2013 and that she had had prior neck injuries at work that had resolved. It was noted that Petitioner had radiation of pain into the right upper extremity and that the pain was located in the right lower cervical/upper thoracic area. It was noted that physical therapy seemed to help with her right hand pain, but did not help her neck. Petitioner underwent chiropractic treatment for the timeframe of March 17, 2014 through July 21, 2014. (PX5).

The records of Tri-County Chiropractic Centre reflect that at the time of the April 4, 2014 visit, Dr. Cochran sent a letter to Dr. Riley stating that Petitioner had presented seeking relief from neck stiffness, headaches, burning along her shoulder blades and numbness/tingling into the last two fingers of her right hand. It was noted that Petitioner reported that her headaches were helped by muscle relaxers and anti-inflammatories but recently had worsened again, and that she noted her symptoms were "definitely aggravated" when she worked, even if she had to sit for prolonged periods. It was noted that neck flexion increased her symptoms, and that she had to do this when filing at work. It was noted that Dr. Cochran's working diagnosis was cervical sprain/strain/nerve irritation, and that as to the symptoms into the right hand, she was advised that should they persist he would order further diagnostics. It was noted that Dr. Cochran thought it might be a case of double crush syndrome. At the time of the April 7, 2014 visit, it was noted that Petitioner presented with increased upper extremity symptoms on the right and now some on the left side to a lesser degree. It was noted that Petitioner stated the neck pain and stiffness had been worse again since yesterday and that she could not relate any aggravating activities. Petitioner was recommended to undergo an MRI of the cervical spine. (PX5).

The records of Tri-County Chiropractic Centre reflect that an Authorization for Absence was issued on April 16, 2014, indicating that in order to avoid aggravation of her condition, Petitioner was recommended to be excused from work April 17, 2014 until May 2, 2014. At the time of the May 2, 2014 visit, it was noted that Petitioner's whole hand went "tingly" for about three hours the day before and was

just in the back of her triceps on that date. It was noted that Petitioner's neck was hurting pretty badly and that it felt like she was going to get a tension headache. It was also noted that Petitioner was going to try to return to work light duty, and in the meantime they were going to try to set her up for an appointment with a neurologist or other specialist. At the time of the May 12, 2014 visit, it was noted that Petitioner stated that she had been experiencing terrible headaches and that she had gone to the emergency room on May 9, 2014. It was noted that Petitioner had continued to experience intermittent symptoms into the upper extremities bilaterally with the right side feeling very weak, and that they were waiting approval on seeing a specialist. (PX5).

The medical records of Cedar Court Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner underwent an MRI of the cervical spine on April 8, 2014 for neck and shoulder pain. The study was interpreted as revealing mild posterior leftward bulging of the C4-C5 disc with minimal encroachment upon the ventral thecal sac and central left neural foramina; mild posterior central bulging of the C5-C6 disc with minimal encroachment upon the ventral thecal sac; posterior leftward bulging of the C6-C7 disc with minimal encroachment upon the ventral thecal sac. (PX6).

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner was seen on May 9, 2014, at which time it was noted that she stated that she was being treated for three bulging disks in her neck, that she was going to therapy, that she felt like she could not move her feet or arms and that they felt tingly. It was noted that Petitioner stated that she was getting into the hot tub prior to her arrival, and that this was when it all started and that her "toes just seized up." The impression was noted to be that of chronic neck pain and hyperventilation syndrome. (PX7).

The medical records of Orthopedic Center of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner was seen on July 28, 2014, having been "referred by word of mouth by a former patient." It was noted that Petitioner's chief complaint was that of neck pain with headaches to the right trapezius, right shoulder, down the right arm to her hand with numbness and tingling in her right hand. It was noted that Petitioner had occasional soreness and pain on the left side, but it was not the greater problem for her. It was noted that Petitioner stated that on December 28, 2013 she was attacked by a male patient, punched in the face and grabbed in the neck. It was noted that Petitioner had three months of conservative care, had no significant improvement and that an MRI was ordered. It was noted that Petitioner's symptoms remained constant and worse with arm activity, overhead work and fixed head positions and better with a neutral position. It was noted that the MRI of April 8, 2014 was reviewed and was of moderate quality, and showed an obvious annular tear at C4-5 and C5-6 which produced central left-sided herniation at C4-5 without cord compression and a central herniation at C5-6 without cord compression, as well as a mild protrusion at C6-7. It was noted that Dr. Gornet discussed the concept of a structural injury to the neck and/or shoulder. Petitioner was recommended to undergo a new cervical MRI and a shoulder MRI, as well as having been referred to Dr. Tanaka. Petitioner was allowed to return to work light duty with a 10-15 pound limit and no overhead work. Petitioner was also given anti-inflammatories and muscle relaxants for her neck and was asked to obtain her records from primary care physician or Dr. Cochran. (PX8).

The records of Orthopedic Center of St. Louis reflect that Petitioner was seen on September 29, 2014, at which time it was noted that her MRI clearly showed a central herniation/annular tear at C5-6 and to a lesser extent at C4-5. It was noted that Petitioner's symptoms were predominantly left-sided and that her exam showed mild weakness in the biceps bilaterally. It was noted that the annular tear was more significant on the left at C5-6, which Dr. Gornet thought was probably the main culprit of her left-sided symptoms. Petitioner was recommended to undergo left-sided injections at C4-5 and C5-6, and it was noted that if she was not improved then consideration could be given to cervical disc replacement at C4-5

and C5-6. It was also noted that Petitioner would require a CT myelogram. Petitioner was continued on work restrictions at that time. (PX8).

The records of Orthopedic Center of St. Louis reflect that Petitioner was seen on December 1, 2014, at which time it was noted that she continued to have neck pain into both sides, right trapezius, right shoulder and right arm, but also the left scapula. It was noted that Petitioner had been recommended disc replacement surgery at C4-5 and C5-6. It was noted that Petitioner recently had injections, but she stated they had not given her any significant relief. Petitioner was continued on work restrictions at that time. At the time of the February 9, 2015 visit, it was noted that Petitioner's CT myelogram was reviewed and revealed no evidence of any significant facet arthropathy, which would be a contraindication to her disc replacement. It was noted that it revealed a large herniation at C5-6 with some caudal expansion, that there was a secondary extrusion at C4-5 which abutted up to the cord but did not dramatically deform it and that other levels appeared to be "clean." Petitioner was continued on work restrictions at that time, and it was noted that her light duty had run out and that she was off work. It was noted that Petitioner's exam was unchanged and that approval was sought for surgery. (PX8).

The records of Orthopedic Center of St. Louis reflect that Petitioner returned to Dr. Gornet on April 9, 2015 so as to discuss the IME report of Dr. Matz. No physical examination findings were noted at that time. Petitioner was continued on work restrictions at that time, and it was noted that Dr. Gornet awaited approval for treatment. At the time of the July 9, 2015 visit, it was noted that Dr. Gornet had no reason "why not to move forward" with the nerve function studies to evaluate the theory of braxial plexopathy as opined by Dr. Matz. No physical examination findings were noted at that time. Petitioner was continued on work restrictions at that time. It was noted that Dr. Gornet's office would coordinate with Dr. Phillips and that Petitioner was to return in six weeks. At the time of the August 24, 2015 visit, it was noted that Dr. Phillips did not detect any significant EMG findings and felt that Petitioner's problem was not related to ulnar neuropathy but that her symptoms were consistent with a sensory neuropathy at C6, which was consistent with bilobular herniation. It was noted that Petitioner's symptoms for the most part were neck pain with headaches, which were more structural and then into her right arm. It was noted that Dr. Gornet's general belief was that if Petitioner's symptoms continued to affect her quality of life, they would move forward with treatment. Petitioner was continued on work restrictions at that time. (PX8).

The records of Orthopedic Center of St. Louis reflect that Petitioner was seen on November 23, 2015, at which time it was noted that her work status remained the same and was essentially off work as there was no light duty available. No physical examination findings were noted at that time. It was noted that Petitioner had been recommended disc replacement surgery at C4-5 and C5-6 and that they were waiting for approval for treatment. Petitioner was continued on work restrictions at that time. At the time of the February 29, 2016 visit, it was noted that Petitioner's main complaints were really neck pain, headaches, right trapezius, right shoulder, right arm pain into her hand with numbness. It was noted that Petitioner's history was unchanged and that her exam was unchanged. Petitioner was continued on work restrictions at that time. Petitioner was again recommended disc replacement surgery. At the time of the June 27, 2016 visit, it was noted that Petitioner continued to have significant structural symptoms including neck pain and headaches, but also irritation into her right trapezius, right shoulder and arm. It was noted that in no other aspect of musculoskeletal care did they forego treatment based on nerve compression or nerve function studies, and that in most aspect of orthopedic care there was no correlation between abnormal nerve function studies and the requirement for treatment. It was noted that Petitioner had tried and failed conservative treatment and had lived with the problem for some time. Petitioner was continued on work restrictions at that time. At the time of the November 23, 2016 visit, it was noted that Petitioner remained on light duty and that her exam was unchanged. Petitioner was dispensed medications. (PX8).

The medical records of Regeneration Orthopedics (9A) and St. Luke's Hospital (9B) were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner was seen by Dr. Tanaka on August 6, 2014, at which time it was noted that she reported right shoulder pain with a date of injury of December 28, 2013. It was noted that Petitioner reported that she was hit in the face and then grabbed by the neck by the patient with both hands, after which she and another worker were able to wrestle the patient to the ground. It was noted that Petitioner denied any significant injury and denied any dislocation or popping in her shoulder at that time. It was noted that Petitioner reported that she was able to ambulate afterwards and did not note any significant injury at that time, but due to persistent pain she was seen in the emergency room and diagnosed with a wrist sprain and began to have increasing numbness approximately one week later. It was noted that Petitioner had been seen by a chiropractor and also underwent physical therapy, where it was noted that she had a decrease in grip strength. It was noted that Petitioner reported no history of problems or symptoms similar to this prior to this injury and that she reported that overall her symptoms had not improved despite therapy. It was noted that Petitioner localized the pain over the anterolateral aspect of the shoulder, but was more concerned about the numbness throughout the arm than she was about the pain. It was noted that Petitioner's primary symptoms were burning pain throughout the arm, as well as numbness in the hands and a sensation of weakness. It was noted that Petitioner had recently been seen by Dr. Gornet for her neck, and that he referred her for an MRI of the cervical spine and had kept her on light duty. The assessment was noted to be that of a 33-year-old female with right shoulder rotator cuff strain and right hand numbness, likely cervical in origin. It was noted that while Petitioner had some symptoms of shoulder impingement and rotator cuff strain, it appeared that her primary symptoms were neurological in nature given her symptoms of weakness and numbness throughout her arm. Petitioner was given a subacromial cortisone injection and prescribed physical therapy. An EMG was also discussed, but it was decided to hold off on it until Dr. Gornet was able to evaluate Petitioner after her cervical spine MRI. (PX9).

The records of Regeneration Orthopedics (9A) and St. Luke's Hospital (9B) reflect that Petitioner underwent x-rays of the right shoulder at St. Luke's Hospital on August 8, 2014, which were interpreted as revealing mild widening of the right AC joint, which may represent an AC separation but there is no adjacent soft tissue swelling; the relationship between the humeral head and the glenoid is normal; there are no findings of a fracture. X-rays of the right elbow performed on the same date were interpreted as revealing a normal examination without fracture, dislocation, arthropathy or focal bone lesion. A Work Status Report was issued on August 6, 2014, allowing Petitioner to return to work with restrictions per Dr. Gornet. (PX9).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. Petitioner underwent an MRI of the right shoulder on August 6, 2014, which was interpreted as revealing (1) supraspinatus tendinosis without significant partial thickness or full thickness supraspinatus tendon tear; (2) otherwise unremarkable MRI of the shoulder. (PX10).

The medical records of Center For Medical Arts were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Petitioner was seen on September 21, 2014 for neck pain. It was noted that Petitioner's symptoms began on December 28, 2013, that the symptoms were reported as being severe, that the symptoms occurred constantly and that the location was the left neck, left-sided headache and left jawline. It was noted that Petitioner had a history of a neck injury at work on December 28, 2013, was a mental health technician and was assaulted by a client and had had chronic left-sided neck pain since then. It was noted that Petitioner's current flare-up began the evening of September 19, 2014 that there were no known inciting factors. It was noted that Petitioner drove one hour each way to work, was on light duty and sat in a chair. It was noted that the back of Petitioner's left neck hurt, went up to the top of her head on the left and down to the upper left back, and that it hurt worse with turning of the head ("knife-like") and went to both sides of the neck. It was noted that Petitioner's last visit was for back pain ("lumbar – fell off step stool") on February 23, 2014. It was noted that Petitioner had missed

work yesterday, today and did not feel she would be able to go tomorrow and wanted a work slip, documenting her recurrence of neck pain from the workers' compensation injury. The assessment was noted to be that of cervical disc disease, recent flare-up of pain. Petitioner was instructed to continue her medications and follow-up as scheduled with Dr. Gorner or her primary care physician sooner if she was not getting any relief. (PX11).

The medical records of Pain and Rehabilitation Specialists of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Petitioner underwent a left C4/5 epidural steroid injection on October 13, 2014 for a diagnosis of cervical disc disease, cervicalgia. (PX12).

The medical records of St. Louis Spine and Orthopedic Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner underwent a left C5/6 epidural steroid injection on October 27, 2014 for a diagnosis of cervical disc displacement. (PX13).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Petitioner underwent a CT cervical spine post-myelogram on February 9, 2015, which was interpreted as revealing (1) let paracentral-lateral recess C4-5, central C5-6 and left paracentral C6-7 disc herniations each resulting in dural displacement, but no central canal stenosis; there is mild ventral cord flattening at the C5-6 level; no foraminal stenosis is detected. (PX14).

The medical records of Neurological & Electrodiagnostic Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. Petitioner was seen on August 24, 2015 for an electrodiagnostic medical consultation by Dr. Phillips. The chief complaint was noted to be that of neck and upper extremity pain, numbness and weakness. The study was interpreted as revealing no evidence for ulnar neuropathy across the right elbow; dynamic cubital tunnel compression does generate sensory symptoms in the thumb and index fingers, which correlates with C6 radiculopathy; a central herniation can generate C6 sensory symptoms from cord irritation without necessarily being reflected in the EMG which evaluates the motor output. (PX15).

The transcript of the deposition of Dr. Matthew Gornet was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. Dr. Gornet testified that he first saw Petitioner on July 28, 2014. He testified that Petitioner reported that her main complaint was neck pain, headaches, to the right trapezius, right shoulder down the right arm to her hand with numbness and tingling in her right hand, and that she also had soreness and pain on the left side but this was not as great of a problem for her as her right-sided symptoms. He testified that Petitioner stated that her problem began on or about December 28, 2013 when she was attacked by a male patient at Chester Mental Health, punched in the face and grabbed in the neck. He testified that Petitioner initially was felt to have more wrist and thumb injuries, and that her pain gradually progressed. He testified that Petitioner had been maintained on light duty until May when her symptoms became worse, that she had three months of conservative care and that she had no significant improvement. He testified that Petitioner's symptoms remained constant, fairly significant, worse with certain positions of her head and that her predominant symptoms were on the right side, but that she denied frank weakness. (PX16).

Dr. Gornet testified that he felt that Petitioner had mild decrease in biceps bilaterally at 4/5, that her sensation was normal, that plain radiographs showed what he felt was no significant bony or degenerative changes and that Petitioner had good range of motion on flexion/extension. He testified that the MRI of April 8, 2014 showed an obvious annular tear at C4-5 and C5-6, that it showed a left-sided herniation at C4-5 without cord compression, a central herniation at C5-6 without cord compression and a mild protrusion at C6-7. He testified that he felt that Petitioner's shoulder pain emanated from her cervical spine but that he referred her to Dr. Tanaka to confirm there was no other significant shoulder

pathology. He testified that he felt that Petitioner was capable of working light duty and that he prescribed anti-inflammatories and muscle relaxants. (PX16).

Dr. Gornet testified that at the time of the September 29, 2014 visit, the new MRI showed a central herniation, annular tear at C5-6 and to a lesser extent at C4-5. He testified that Petitioner's symptoms on that visit were more left-sided than right again, but that she continued to show mild weakness bilaterally and that he told her that the herniation was probably more significant on the right and the annular tear more on the left. He testified that he recommended injections. He testified that when he next saw Petitioner on December 1, 2014, he noted that the injections had not given her any significant relief so he discussed surgery. He testified that Petitioner had failed conservative care including chiropractic care and injections, and that he thought the option would be to replace the discs at C4-5 and C5-6. He testified that he next saw Petitioner on February 9, 2015, at which time a CT myelogram was obtained. He testified that the CT myelogram did not show any evidence of facet changes or facet arthropathy and that it clearly revealed a large herniation at C5-6 with some caudal expansion and secondary extrusion at C4-5 which abutted up to the cord but did not dramatically deform it. He testified that his plan was surgery at C4-5 and C5-6 and that Petitioner remain on light duty. (PX16).

Dr. Gornet testified that he next saw Petitioner on July 9, 2015, at which time she brought with her the IME report of Dr. Matz. He testified that for the most part Petitioner had very clear objective pathology not only on CT myelogram, MRI and on objective physical examination findings that were all consistent with her subjective complaints, and given that she had failed conservative measures, he did not believe that there was any further value in looking at it. He testified that he did not have any problem with Petitioner getting nerve function studies, but it was not an area of significant nerve compression. He testified that he did not feel that Petitioner was having significant spinal cord displacement and so it would be unlikely that she would have significant EMG or nerve function findings. He testified that he referred Petitioner to Dr. Phillips, a local neurologist, for the nerve conduction studies. (PX16).

Dr. Gornet testified that he next saw Petitioner on August 24, 2015, and noted that Dr. Phillips did not detect any issues of brachial plexopathy as assessed by Dr. Matz. He testified that there was nothing more to do other than surgery to fix it, and that if he had fixed it a long time ago Petitioner would have been back to work full duty with no restrictions one year ago. He testified that kyphosis was a slight forward curvature of the spine and that Petitioner was relatively neutral. He testified that the fact that Petitioner had bilateral symptoms was not a measure for or against treatment, and that it would more indicate that she had a global injury to the disc and disc mechanism. He testified that the fact that Petitioner's complaints waxed and waned may just be related to simple inflammatory changes that could wax and wane from a cellular basis, but that her complaints bilaterally were consistent with her objective studies. (PX16).

Dr. Gornet testified that he had reviewed the utilization review report, and that the ODG was a "sham" guideline. He testified that if one truly wanted to get a utilization review, you would request it by a peer who actually did cervical disc replacement. He testified that he researched Dr. Fossier, who had not practiced in years and did not have an office number. He testified that he was over age 76 and did not believe that he had ever done two-level cervical disc replacement. (PX16).

Dr. Gornet testified that he recommended that Petitioner remain on light duty, and that the light duty recommendations that he made were reasonable and necessary. He testified that the diagnosis was disc injury at C4-5 and C5-6 with discogenic pain, as well as mild radicular pain bilaterally. He testified that he believed that Petitioner's current symptoms and requirement for treatment was causally connected to her work-related injury as described. He testified that the care and treatment to date that he had recommended and provided was reasonable and necessary. When asked of his prognosis for Petitioner's condition following surgery, Dr. Gornet responded that his expectation would be for her to be able to

return back to work full duty, no restrictions, approximately 3-4½ months post-surgery barring any complications. (PX16).

On cross examination, Dr. Gornet testified that he did not know if he had Dr. Cochran's medical records but that he had multiple records of Dr. Riley. As to the February 26, 2014 note of Dr. Riley and whether or not he mentioned neck pain in the note, Dr. Gornet testified that he did not see anything mentioned about a physical examination in the note. He testified that he did not have the medical records of Occupational Performance Rehab. (PX16).

On cross examination, Dr. Gornet testified that on July 28, 2014, Petitioner's subjective complaints were predominantly on the right but that she had some left-sided complaints and that on the following visit, they were predominantly on the left. He agreed that he documented pain into the right trapezius, right shoulder, down the right arm to the hand with numbness and tingling. He testified that he referred Petitioner to a shoulder specialist because he wanted to make sure that there was no shoulder pathology that was causing similar symptoms. He testified that Petitioner's subjective complaints on the right side in conjunction with the physical exam had him include in his differential diagnosis to rule out right shoulder pathology. He agreed that Petitioner's subjective complaints on her left side and physical exam did not cause him to put in his differential diagnosis to rule out left shoulder pathology. (PX16).

On cross examination, Dr. Gornet agreed that when he saw Petitioner on September 29, 2014, he would have had a copy of the MRI scan by the time that he saw her in his office but that he would not have had Dr. Ruyle's notes. He agreed that his notes for that date indicated that Petitioner's symptoms were predominantly left-sided. He testified that Petitioner was still having right-sided symptoms but that the left side was more bothersome than the right subjectively. He testified that Petitioner's imaging revealed that she did not have significant degeneration throughout her spine, but that she did have age-appropriate degeneration. He testified that the change in disc hydration probably pre-dated her incident. He testified that the annular tears and herniations that he described on the MRIs could have been caused by trauma or anything where the stress on the disc exceeded what the annulus could handle. He testified that degeneration did not cause annular tears, but was always seen in conjunction with a disc herniation or an annular tear. (PX16).

On cross examination, Dr. Gornet testified that people can have degeneration and have symptoms that wax and wane, but that this was different than persistent mechanical neck pain, headaches and mild radicular pain. He testified that Petitioner had structural neck pain, headaches and mild radicular pain on both sides and that while her symptoms had waxed and waned, it was fairly consistent with her clinical diagnosis. He agreed that Petitioner's symptoms were more on the right side since September 29, 2014. He agreed that the last note was August 24, 2015, which was the point at which Petitioner had undergone the EMG/nerve conduction study. He agreed that the EMG did not disclose evidence for denervation potentials or loss of motor units in the upper extremity muscles. (PX16).

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Illinois Form 45: Employer's First Report of Injury noted that Petitioner was passing out snacks when an unhappy patient got mad and attacked her, hitting her in the mouth twice and then trying to choke her. It was noted that Petitioner and another co-worker got the patient to the ground and that Petitioner smashed her right hand on the ground. It was noted that multiple body parts were affected. The Workers' Compensation Employee's Notice of Injury noted that Petitioner hit her right thumb and first finger area, and was struck in the neck on the left side and the center mouth area during the course of the altercation. The Supervisor's Report of Injury or Illness noted that Petitioner was hit in the face causing her to fall to the floor, and that the body parts injured were that of the nose, mouth, left side of the neck and right hand. The Staff Injury Summary noted that Petitioner was attacked by a patient and knocked to the floor, hitting her right thumb and knuckle of the index finger. The Initial

Workers' Compensation Medical Report completed by Dr. Riley noted that during an injury at work, Petitioner fell on her right hand and sustained a contusion to the left mandible. The nature and extent of the injuries sustained were noted to be that of a soft tissue injury including ligamentous sprain of the right hand. (RX1).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The Section 12 Report of Dr. Paul Matz was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report reflects that an IME was performed by Dr. Matz on February 26, 2015, at which time Petitioner reported that on the date of the accident, she was sitting at a table doing administrative work and also passing snacks to patients. It was noted that there was an altercation, that one of the patients became threatening to her and that she was ultimately going to switch places with another guard. It was noted that when the two guards looked at each other, the patient attacked Petitioner. It was noted that Petitioner reported that the patient struck her in the face and right jaw and grabbed her neck, and that she was amnestic for the rest of the events but then remembered being on the ground, having been knocked down. It was noted that Petitioner ended up trying to grab the patient from the floor and rolled her wrist, and that she was not sure which side she was on. It was also noted that there were some reports of falling on the right arm, but that Petitioner did not remember this. (RX3).

The report of Dr. Matz reflects that Petitioner noted that she had pain that was located in her right wrist and thumb, and that she stated that her thumb and hand were swollen. It was noted that during occupational therapy, Petitioner increased strength in her hand and was able to splint it and rehabilitate it but that she stated the more she tried to regain strength, the more she had to do repetitive motions and the more her hand would shake and she would have a sense of fatigue. It was noted that Petitioner stated that she noted pain on the inside of her shoulder blade and then the right shoulder, and that when she would do work overhead it would be problematic. It was noted that Dr. Matz asked why the therapist did not work on her neck, and that Petitioner stated that she was only approved to do work on her hand. It was noted that Petitioner continued to rehabilitate her right side and that it was thought that her shoulder problems were due to her overworking her left side because it was the dependent side due to weakness from the right hand injury. It was noted that Petitioner's hand improved in power and that she then wanted to focus on her neck. (RX3).

The report of Dr. Matz reflects that Petitioner's current symptoms were pain that was located in the right wrist and that she reported no associated weakness or numbness in her hand. It was noted that Petitioner's hand pain was eccentric to the right and associated with her hand injury, and that she stated that when she wrote and used the arm she had some neck pain and some pain down around the right upper arm and located over the right trapezius and right neck. It was noted that Petitioner did not report bothersome symptoms on the left side, that Petitioner stated that she had no neck pain on the left side but occasionally would get some slight left shoulder pain but was quite minor. (RX3).

The report of Dr. Matz reflects that his diagnoses were trauma to the right wrist and an underlying right wrist soft tissue injury. It was noted that Petitioner's right hand condition was treated with occupational therapy and was related to the work injury of December 28, 2013. It was noted that Dr. Matz opined that Petitioner suffered a cervical neck strain when her neck was grabbed and when she was punched. It was noted that Petitioner's right arm pain and hand tingling, trapezius pain and diminished lifting of the shoulder would be consistent with a brachial plexus upper trunk injury. It was noted that Petitioner had some cervical kyphosis evident on her July 28, 2014 x-rays and that she had some underlying cervical degenerative disease that was temporarily exacerbated by her neck being grabbed and strained. It was noted that the annular fissures described by Dr. Gornet were eccentric to the left and did not match Petitioner's symptoms. It was noted that the fluctuation in Petitioner's symptoms would be

more consistent with the history of a cervical degenerative process, and that the alternative possibility would be that her symptoms were outside of the neck and brachial plexus in nature, which would fit with her right arm injury and her right arm pain persistence. It was noted that if the neck were the primary source of traumatic change Petitioner would either have right-sided radiographic pathology in the neck accounting for right arm symptoms, or she would have consistent severe left-sided clinically severe symptoms to match radiographic abnormalities. It was noted that Petitioner's symptoms were right-sided in nature and on the opposite side of the pathology proposed by Dr. Gornet, and that her clinical symptoms fluctuated between July 28, 2014 and September 29, 2014 which would be consistent with a degenerative process and not a traumatic process. It was noted that Petitioner had traumatic wrist injury, brachial plexus pathological injury on the right and a cervical strain all related to her injury as well as a temporary exacerbation of her cervical degenerative kyphosis, and that her annular fissures were not related to her injury. (RX3).

The report of Dr. Matz reflects that he indicated that it was not logical for him to reconcile left-sided radiographic pathology to right-sided clinical symptoms, and that it was his opinion that the need for disc replacement for annular disruptions (1) conflicted with her site of pathology and reported symptoms, and (2) would be for a degenerative process as the symptoms were fluctuating as they did between the July 2014 and September 2014 exams, rather than a traumatic process. It was noted that Petitioner had chronic kyphotic deformity as evidenced by her July 28, 2014 x-rays, and that the choice to do cervical total disc replacement was contraindicated in the presence of her kyphosis. It was noted that Dr. Matz thought it was premature to consider surgery and that Petitioner needed to be evaluated for brachial plexopathy on the right side, and that surgery would be treating left-sided radiographic degenerative pathology which was without any nerve compression which Dr. Matz would not recommend in the interest of managing and improving Petitioner's symptoms. (RX3).

The report of Dr. Matz reflects that he opined that Petitioner had not reached maximum medical improvement given her ongoing complaints and findings suggestive of brachial plexopathy and that she had not been adequately evaluated diagnostically. It was noted that it was Dr. Matz's opinion that an EMG/nerve conduction study of both arms should be undertaken to look for any cervical radiculitis and also brachial plexopathy and that if the study was unrevealing and did not indicate cervical radiculopathy or brachial plexopathy, that consideration for evaluation by a physiatrist for management to help Petitioner's arm pain would be helpful. It was noted that Dr. Matz did not believe total disc replacement would be in Petitioner's best interest and that evaluation by a physiatrist would be fruitful. It was noted that Dr. Matz opined that Petitioner would be working at sedentary duty, including lifting under 10 pounds and that the duration would be until her studies were done and further medical management could be ascertained. (RX3).

The transcript of the deposition of Dr. Paul Matz was entered into evidence at the time of arbitration as Respondent's Exhibit 4. Dr. Matz testified that he is a practicing neurological surgeon and is board-certified in neurological surgery through the American Board of Neurological Surgery. (RX4).

Dr. Matz testified that he reviewed the actual films for the cervical x-rays performed on July 28, 2014, a cervical MRI of April 8, 2014, a cervical MRI of September 29, 2014 and a cervical CT myelogram of February 9, 2015 and that the films were of good quality. He testified that he took a history from Petitioner and that her current symptoms were that of pain in the right wrist without weakness or numbness in the hand, that when she would write or try to use the arm she would get some neck pain that was down the right arm over the trapezius and in the right neck, and that she did not report any bothersome symptoms on her left side and did not have any complaints of neck pain on the left, but would occasionally get left shoulder pain that she described as minor. (RX4).

Dr. Matz testified that Petitioner had a relatively normal examination of the neck and that she had discomfort when she turned, had slightly limited range of motion and had weakness in the deltoids. He testified that 4+ was near normal strength in the deltoid and that one was able to hold strength but it could be broken. He testified that his opinions were that Petitioner had a trauma to her right wrist and soft tissue injury, that she suffered a cervical strain that improved somewhat with time and analgesics and then had a recurrence of her pain, and that she had a possible brachial plexus injury to her upper trunk injury because of the right hand pain and tingling. He also testified that Petitioner had some cervical disc degeneration as well. (RX4).

Dr. Matz testified that the cervical disc degeneration was observed on the films, and that on her cervical MRI of April Petitioner had some collapse of the disc, especially at C4-5 and C5-6, and that there was some slight narrowing of the spinal canal but no compression of the neural elements. He testified that on the September films Petitioner had some small annular fissures and some kyphosis, and that she had a chronic kyphotic deformity which was seen not uncommonly with cervical degeneration. He testified that he thought the cervical degeneration shown on the films appeared to be more dehydrated, chronic changes that would most likely have been present before the injury, that the kyphosis would have taken some time to develop and that the April MRI in his opinion did not show any acute tears. (RX4).

Dr. Matz testified that annular fissures were sometimes referred to as annular tears. He testified that Dr. Gornet described the fissures in the center of the disc at C4-5 and C5-6, and that they were primarily in the center and that some of the disc herniation was more eccentric to the left. He testified that if one had a disc herniation eccentric to the left, if the nerve root was compressed on the left side then it would be left arm symptoms. He testified that Petitioner complained to him of right arm symptoms. He testified that in reviewing Dr. Gornet's records, Petitioner initially reported right arm symptoms, that there was a period in which she complained of left-sided symptoms and that they then ultimately went back to the right. (RX4).

Dr. Matz testified that he did not believe that Petitioner needed the surgery recommended by Dr. Gornet as a result of the December 2013 injury because her pathology was on the left side and not the right and that Petitioner's symptoms were on the right side, so there was discordance. He testified that Petitioner also had kyphosis, which was a relative contraindication to doing disc replacements. He testified that it was his opinion that the fluctuation in symptoms and changes were more consistent with a degenerative process, but that he felt pretty strongly that the discordance in symptoms – *i.e.*, right arm pain for left-sided pathology – would not be an indication for the disc replacement. (RX4).

Dr. Matz testified that when he looked at the initial April MRI he did not see the annular fissures as described by Dr. Gornet, so if they developed they developed in the interval timeframe and would be more of a manifestation of degenerative changes. He testified that on the imaging studies that he saw he did not see any nerve compression in the cervical spine but that there was some narrowing, and that there was still some spinal fluid between the neural elements and the disc so that there was not active compression of the nerve roots. When asked if there was any objective evidence to support Petitioner's subjective right arm pain, Dr. Matz responded that there was a history of trauma and limitation in the shoulder. He testified that the MRI did not show active compression of the nerve roots on the right and that the CT myelogram did not indicate any active compression of the right C5 nerve root. He testified that a differential diagnosis for Petitioner was that of a brachial plexus injury for which he recommended an EMG/nerve conduction study. (RX4).

Dr. Matz testified that if Petitioner underwent the EMG/nerve conduction study and it did not show any radiculopathy from the cervical spine and did not show any brachial plexus injury, one interpretation was that Petitioner injured the brachial plexus and it recovered. He testified that if Petitioner had a C6 radiculopathy that did not show up on an EMG, there would be objective evidence on

the imaging studies. He testified that if Petitioner did not have any objective evidence on MRI or CT and the EMG/nerve conduction study did not show any radiculopathy in the cervical spine, it was his opinion that the arm pain would probably be more either due to the soft tissue injury itself or a brachial plexus injury that was self-limiting and recovered but with some residual pain. (RX4).

When asked if he had an opinion as to whether or not Petitioner needed any further treatment with regards to her work injury of December 2013, Dr. Matz responded that the only other thing that he would add as a treatment to try was that of treatment with a physiatrist. He agreed that as of the time of the IME in 2015, he thought Petitioner could work sedentary duty. He testified that he has had patients do work hardening and if they could handle it then they would be cleared, and that if they could not then he would have them undergo an FCE to objectively study what they were capable of doing. (RX4).

On cross examination, Dr. Matz admitted that he did not know exactly where Petitioner was punched in the face. He admitted that he was not aware of which side of the neck was grabbed during the incident, but that he did not know that the specific side would make a huge difference more than just the act of the trauma. He testified that a strike to the left or to the right would not necessarily have any bearing on his formulation of a causation opinion, and that it was the amount of energy that the neck had to absorb and the ability of the muscles to guard it. When asked if he knew any details about how Petitioner landed on the ground after she was grabbed by the neck, Dr. Matz responded that he did not know much because Petitioner stated that she was amnestic to the event. (RX4).

On cross examination, Dr. Matz testified that he felt that Petitioner was credible in relaying her history to him and that he felt that she was credible in relaying her symptomatology to him. He testified that he did not have any reason not to believe that Petitioner was credible in his examination of her. He agreed that if he felt that Petitioner was not credible during the examination, he would have documented it in his report. He agreed that Petitioner had reported both left- and right-sided symptoms of the cervical spine and upper extremity. (RX4).

On cross examination, Dr. Matz testified that on the intake form Petitioner completed at the time of the IME she indicated that her neck down to the middle of the shoulders was affected and was throbbing, burning, sharp in quality and moderate to severe in severity after the physical altercation that occurred. He testified that Petitioner also indicated that she had pain in the shoulder down the right arm, worse with activity. He testified that in the absence of nerve root compression, he would expect Petitioner to have some pain relative to the degeneration in the neck and between the shoulder blades from mechanical pain in the neck. He agreed that on the date of the IME, Petitioner had predominant symptoms in the right arm and that the ones she had on the left side were very minor and not bothersome to her. (RX4).

On cross examination, Dr. Matz agreed that at the time of the September 21, 2014 visit with Dr. Travis, Petitioner reported that her symptoms were more left-sided. He agreed that at the time of the September 29 2014 visit with Dr. Gornet, Petitioner's symptoms were predominantly left-sided. He agreed that he did not see any documentation that Petitioner was not working full time at the time of the accident. He agreed that the only injury that he was aware of was Petitioner's accident as she described. He agreed that the only history of trauma by Petitioner was the work accident. He agreed that the neck and upper extremity symptoms began after the date of accident and that she sought treatment for them following the date of accident. (RX4).

On cross examination, Dr. Matz agreed that he did not have any criticism of the treatment provided by Dr. Gornet. He testified that that he did, however, disagree with it as the indication for doing a total disc replacement was active radiculopathy symptoms that were not improving and, in the absence of active left-sided symptoms which Petitioner had on the date of the IME, he would not pursue surgery.

He agreed that the radiologist on the September 29, 2014 MRI report indicated that there was pathology on each side of C5-6. (RX4).

On cross examination when asked if the nerve conduction study had shown radiculopathy whether he would agree that surgery would be a reasonable option, Dr. Matz responded that it would not in the absence of active nerve root compression. He testified that in the absence of active nerve root compression, the result of multi-level neck surgery and the control of neck and shoulder blade pain were speculative at best. He agreed that he did not dispute that there was objective radiographic pathology on each side of the cervical spine, and that Petitioner from the date of accident had complained of symptomatology to both sides of her body. (RX4).

On cross examination, Dr. Matz agreed that there was foraminal narrowing on the radiographic scans and that it could create the possibility of nerve impingement but testified that it had to get severe. He testified that there was a buffer of cerebrospinal fluid around every nerve root sleeve, so it was his opinion that the severity was not enough to take up all of the CSF space and start impinging on the nerve space. (RX4).

On redirect, Dr. Matz testified that foraminal narrowing could be part of the degeneration process in a person's spine. He testified that Petitioner's BMI category placed her in the obese category. He testified that there was a correlation between obesity and joint degeneration, but that he did not know how specific it was with the neck or the low back. (RX4).

On redirect, Dr. Matz agreed that the February 12, 2014 note of Dr. Riley was generated less than two months after the accident. He agreed that when he reviewed the records, he made note of whether or not Petitioner had any neck pain on the various dates. He testified that he was evaluating Petitioner for her cervical spine condition. He agreed that he was interested in reviewing the notes to see what Petitioner was complaining about at various times. He testified that in the February 12, 2014 note, there was nothing in the list of medications that would control pain. He testified that if someone suffered a traumatic injury to the neck, he would expect someone to report pain in the immediate timeframe after the injury. He testified that most of the records from Petitioner's family physician in January and February of 2014 focused on Petitioner's right hand and wrist. (RX4).

On redirect, Dr. Matz testified that a person that has symptoms that waxed and waned was consistent with a degenerative process, and that a trauma would be more of an initial crescendo and a decrescendo phenomenon. He testified that in his review of Petitioner's medical records, she had a waxing and waning and fluctuation between the sides and changing in severity where she had a "quiet period" and then her symptoms increased in the spring of 2014. (RX4).

On redirect, Dr. Matz testified that a two-level disc replacement would not be logical for left-sided annular tears with predominant right-sided symptoms and a lesser degree of left upper extremity symptoms, but that it would be indicated if Petitioner had active nerve root compression of the right side and presented with what she indicated in February to as enduring right arm pain. He testified that Petitioner did not have active compression of the nerve roots based on the myelogram and the MRIs. (RX4).

On further cross examination, Dr. Matz testified that a nerve conduction study did not measure pain. (RX4).

The medical records of Dr. Phillips were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records were effectively duplicative of those as contained in Petitioner's Exhibit 15. (RX5; PX15).

The Utilization Review Report dated March 19, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report noted a determination of non-certification for continued occupational therapy as ordered by Dr. Riley. It was noted that Petitioner had completed twelve occupational therapy sessions and while she continued to report some pain issues with her right hand after suffering a soft tissue injury, there were no clinical deficits noted in the documentation. It was noted that the guidelines allowed for fading of treatment frequency plus active self-directed home physical therapy, and that more visits may be necessary when grip strength was a problem even if range of motion was improved. The report was prepared by Dr. Peter Lopez, whose practice type was identified as Family Practice. (RX6).

The transcript of the deposition of Dr. Kenneth Smith, Jr. was entered into evidence at the time of arbitration as Respondent's Exhibit 7. Dr. Smith testified that he is board-certified in neurosurgery and that he holds a medical license in Missouri. He testified that he has treated conditions involving the cervical spine, both conservatively as well as surgically. (RX7).

Dr. Smith testified that he was asked to determine whether or not cervical spine surgery was needed as part of the utilization review, and that he determined that he did not think that Petitioner needed any cervical disc surgery at the time the review was performed. He testified that he relied upon mainly the x-ray reports and Dr. Matz's report as well as the other medical records provided. He testified that it did not meet the Official Disability Guidelines for cervical disc surgery. (RX7).

Dr. Smith testified that an attempt was made to contact Dr. Gornet regarding the findings, and that the peer-to-peer call was attempted on December 30, 2015 and December 31, 2015 but no further attempt was made after the report. He testified that Dr. Gornet was not reached with those calls, nor did he ever return those calls to his knowledge. He testified that he did not know if Dr. Gornet appealed his findings. (RX7).

On cross examination, Dr. Smith testified that he was not practicing neurosurgery and was teaching at the university hospital and also did Social Security. He testified that his neurosurgery practice ended in 2008. He testified that he last performed surgery in 2008. When asked if he had ever performed an artificial disc replacement surgery, Dr. Smith responded that he thought he had assisted but did not recall personally doing an artificial disc replacement on his own. He testified that he may have assisted up to three times over the course of his career on a live patient, and that he had done them on cadavers in a workshop. (RX7).

On cross examination, Dr. Smith agreed that he never actually examined Petitioner. He testified that he reviewed the radiologist's report and Dr. Matz's report of seeing the films from the CT of February 9, 2015. He testified that he reviewed four different doctors' reports and either three or four by Dr. Gornet. He testified that he is 84 years of age. (RX7).

On cross examination, Dr. Smith testified that he believed that the CT cervical spine post-myelogram report was inaccurate as far as referencing a herniation, and that in his opinion 1-2 mm was not his definition of a herniated disc. He testified that when he referred to a herniated disc, it meant that there was a piece of disc that was ruptured out and was pressing on the nerve. (RX7).

On cross examination, Dr. Smith denied having seen the MRI report from MRI Partners of Chesterfield dated September 29, 2014. He denied having reviewed the deposition transcript of Dr. Matz. He agreed that he did not review the MRI films and he further agreed that he did not review the films from the CT scan. He agreed that he reviewed Dr. Phillips' office note but did not agree that the nerve conduction study showed a significant neurologic deficit. He testified that Petitioner had bilateral

numbness and a decreased pin sense in both arms that did not correspond to any nerve root problem. He testified that nerve conduction studies were very reliable in showing no nerve deficits and no peripheral nerve root deficits. He testified that they could not measure pain. (RX7).

On cross examination, Dr. Smith testified that he did not review Dr. Gornet's deposition transcript. He testified that he did not think Petitioner had any neurological deficits and that he did not know where the biceps weakness came from. He testified that Petitioner had no nerve root compression on the myelogram or on the EMG, so there was no objective evidence that she had any nerve root compression that could be helped by a disc operation. He testified that if Petitioner had surgery there was a 10% chance of her getting better, but that there was a 90% chance that she would be "far worse off" after having two artificial disks placed in her neck with no neural compression that had been relieved. (RX7).

On redirect, Dr. Smith testified that he performed neurosurgery for approximately 50 years. He testified that a finding of weakness of 4+ on the right side could be found due to self-limiting due to pain or discomfort. He testified that that the disc bulges that were noted on the CT myelogram were on the left and central, but that Petitioner's complaints were primarily right-sided although he admitted that Dr. Gornet started indicating that it was on the left side. He agreed that this was some of the "issue" that Petitioner's complaints were right-sided and that the herniations were not coming into play with regard to her symptoms. (RX7).

The Utilization Review Report dated January 5, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 8. The report reflects that the cervical disc replacement at C4-5 and C5-6 was non-certified by Dr. Kenneth Smith, Jr. on January 5, 2016. It was noted that Petitioner did not meet ODG guidelines for C4/5/6 surgery as there was no herniated disc and no significant neurological deficit, and that the request was not medically necessary or appropriate. (RX8).

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on December 28, 2013, Petitioner sustained an accident that arose out of and in the course of her employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the cervical spine is causally related to the accident of December 28, 2013.

The Arbitrator finds to be significant in this case the lack of notation regarding complaints of neck pain at the time of the initial post-accident emergency room presentation. The records of Memorial Hospital of Chester reflect that Petitioner was seen on December 28, 2013, at which time it was noted that she was involved in an altercation with a resident at work. It was noted that Petitioner stated that a resident grabbed her neck and hit her and pushed her down, and that she denied injury to the neck and voiced right hand pain. (PX2). The medical evidence in the case reflects that the treatment rendered to Petitioner at the time of and subsequent to the initial emergency room presentation was focused nearly exclusively on Petitioner's right hand and wrist, and that it was not until the March 17, 2014 visit with Dr. Cochran was any treatment specifically directed at Petitioner's neck. (PX5). While the Arbitrator concedes that mention was made of neck pain in the January 13, 2014 note at Christopher Rural Health – REA Clinic, no mention was made of any neck pain at the time of the February 12, 2014, February 26, 2014 or March 12, 2014 visits at this particular clinic. (PX3). That said, the Arbitrator finds the

inconsistent reporting of symptomatology in the neck to be significant as it pertains to the issue of causation.

Furthermore, the Arbitrator does not find Petitioner's testimony that she was told that Dr. Riley's records were switched to new computer system and that a lot of the doctor's notes were deleted and changed to be plausible. The Arbitrator also notes that Petitioner's symptomatology as it relates to the cervical spine appears to be migrating between the right and left upper extremities. While Dr. Gornet at the time of the July 28, 2014 visit noted that Petitioner's chief complaint was that of neck pain with headaches to the right trapezius, right shoulder, down the right arm to her hand with numbness and tingling in her right hand, at the time of the September 29, 2014 visit Dr. Gornet noted that her symptoms were predominantly left-sided. The Arbitrator notes that Petitioner's complaints at the time of the September 29th visit auspiciously coincided with what Dr. Gornet opined was a central herniation/annular tear at C5-6 and to a lesser extent at C4-5, and that the annular tear was more significant on the left at C5-6 which he thought was probably the main culprit of Petitioner's left-sided symptoms. (PX8). The Arbitrator further notes that while Petitioner testified that her pain seems to radiate depending on her activity level and that if she uses her right side more then she would have more pain on the right side than the left, no such distinction appears within any of the medical records from any of the multitude of practitioners that have examined Petitioner since the accident of December 28, 2013. That said, the Arbitrator places little evidentiary weight on Petitioner's testimony on this issue.

Having considered and reviewed the entirety of the medical evidence in this case, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the cervical spine is causally related to the accident of December 28, 2013.

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 by Dr. Matz was performed on February 26, 2015 as well as the EMG/nerve conduction study recommended by Dr. Matz was reasonable, necessary, and causally related to the work accident of December 28, 2013. 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 February 26, 2015 as well as the EMG/nerve conduction study recommended by Dr. Matz,** 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 care, in light of the Arbitrator's finding that Petitioner has failed to prove that her current condition of ill-being in the cervical spine is causally related to the accident of December 28, 2013, Petitioner's request for prospective medical treatment to the cervical spine 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 at the time of arbitration requested temporary total disability benefits for the timeframe of July 29, 2016 through February 8, 2017. (AX1). In light of the Arbitrator's finding that Petitioner has failed to prove that her current condition of ill-being in the cervical spine is causally related to the accident of December 28, 2013, Petitioner's request for temporary total disability benefits for the timeframe of July 29, 2016 through February 8, 2017 is hereby denied.

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

James Marrs,

Petitioner,

vs.

NO: 12 WC 42970

18IWCC0574

Caterpillar, 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 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 September 29, 2017, is hereby affirmed and adopted.

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

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

18IWCC0574

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

DATED: SEP 2 0 2018
TJT:yl
o 9/11/18
51

Thomas J. Tyrrell

Kevin W. Lamboth

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARRS, JAMES
Employee/Petitioner

Case# **12WC042970**

16WC013684

CATERPILLAR
Employer/Respondent

18IWCC0574

On 9/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% 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:

5354 STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

5411 CATERPILLAR INC
AMANDA WATSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

18IWCC0574

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

James Marrs
Employee/Petitioner

v.

Caterpillar
Employer/Respondent

Case # **12** WC **42970**

Consolidated cases: **16 WC 13684**

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 **Peoria**, on **6/20/17**. 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 _____

18IWCC0574

FINDINGS

On 10/11/12, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $40,227.20; the average weekly wage was $773.60.

On the date of accident, Petitioner was 56 years of age, *married* with no dependent children.

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

Respondent *has 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 $12,397.32 for other benefits, for a total credit of $12,397.32.

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

ORDER

Because Petitioner failed to establish that his current condition of ill-being is causally related to the accident of 10/11/12, 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.

Michael K. Nowak, Arbitrator

9/22/17
Date

ICArbDec p. 2

SEP 29 2017

FINDINGS OF FACT

Petitioner has been employed by Respondent since April 25, 2005. Since that time, he has been a welder in Respondent's Building LL in East Peoria, Illinois. He performs work on the "ROPS" line involving D6, D7, D8, D9, D10 and D11 bulldozers (T12). ROPS stands for rollover protection system and, as described by Petitioner, is life support on the dozer (T56, T12).

Petitioner testified on or about October 11, 2012, he was clamping a vice grip type clamp to put a backup strip on the inside of a D11 and when he released the clamp, it struck him in the lower part of his right thumb (Rx4; T50). The pictures entered in Respondent's Exhibit 6 show the type of clamp Petitioner was using at the time of the alleged injury (Rx6). Petitioner testified the right thumb area was swollen very badly and he went to Cat Medical to report his injury (T16). Caterpillar Corporate Medical records indicate Petitioner filled out an incident form on October 12, 2012. At that time, he reported on October 11, 2012, at approximately 9:30 a.m., he was unclamping a vice-type grip when it sprung back and struck the palm of his right hand at the base of the right thumb. He indicated the pain and swelling occurred at the base of the right thumb after he had gone home for the evening around 5:00 p.m. (Rx4). When he first saw a Caterpillar doctor on October 16, 2012 he was diagnosed with non-work related degenerative changes of the right first digit CMC joint and told to follow-up with his family doctor regarding his arthritis (Rx4).

Petitioner testified he used two hands to operate the clamp. Respondent's witness, manufacturing engineer for the large weld area Paige Smothers, also testified she would use two hands for the clamp, but she had never experienced a clamp springing back as described by Petitioner (T67).

Petitioner sought out treatment for his right thumb with Dr. Mahoney at Midwest Orthopaedic Center in Peoria, because he had previously treated Petitioner for a 2008 right middle finger incident that required surgery. The initial office visit took place on November 27, 2012, when Petitioner gave a history of a mid-October 2012 incident at work. X-rays on the date of this visit showed osteoarthritis of the right thumb. Dr. Mahoney indicated the osteoarthritis of the CMC joint of the right thumb had worsened over time and Petitioner would like to proceed with an injection, which was performed on that date (Px4). Petitioner continued to follow-up with Dr. Mahoney.

On January 15, 2013, Petitioner followed-up after his November 2012 cortisone injection. Dr. Mahoney stated in his plan Petitioner had persistent CMC joint osteoarthritis. He recommended an arthroplasty and indicated Petitioner has "garden variety degenerative osteoarthritis of the CMC joint of the thumb, an almost universal problem that will affect everyone that lives long enough" (Px4). Dr. Mahoney states, "I do not believe that his condition was in any way caused by, worsened, contributed, nor made more likely to treat because of his work activities" (Px4). Petitioner last saw Dr. Mahoney on February 18, 2013. On that date, Dr. Mahoney acknowledged he was aware of an injury at work using a vice grip during assembly, but "I do not believe that this injury caused the patient's CMC joint arthritis" (Px4). Again, Dr. Mahoney indicates Petitioner's arthritis is typical osteoarthritis, which affects almost everyone eventually (Px4). Petitioner never returned to Dr. Mahoney for treatment (Px4).

Petitioner testified he visited his primary care physician, Dr. Renick, when he alleged the pain in his right thumb did not subside. Dr. Renick referred Petitioner to Dr. Rhode in Peoria (T19). Dr. Rhode initially

saw Petitioner on March 13, 2013 (Px5). Petitioner gave a history of an October 11, 2012 right thumb injury at work and also described his history of welding duties. He alleged to Dr. Rhode on October 11, 2012, while performing welding on a D11 "ROPS", he was use a vice clamp when the clamp popped and struck the thenar area of his right hand. Petitioner told Dr. Rhode he had been evaluated by Dr. Mahoney who provided an injection. Dr. Rhode also diagnosed Petitioner with localized osteoarthritis of the right thumb. He also recommended an injection, which took place on March 13, 2013. However, he further recommended Petitioner undergo first CMC trapeziectomy. In Dr. Rhode's April 28, 2013 office visit note, he indicates he has reviewed the medical records of Dr. Mahoney, including Dr. Mahoney's reference to a specific injury using a vice grip. Dr. Rhode disagreed that CMC arthritis affects almost everyone eventually and reiterated an opinion that Petitioner's right hand first CMC arthritis was secondary to Petitioner's work exposure (Px5).

Petitioner went on to have the trapeziectomy with Dr. Rhode on October 18, 2013. He was released to return to work full duty thereafter and at MMI on April 9, 2014. He has not seen Dr. Rhode since December 30, 2014 (Rx5).

On October 12, 2015, Petitioner attended an independent medical examination with Dr. Craig Phillips at the Illinois Bone and Joint Institute for evaluation of his right hand and wrist. Petitioner described his normal activities at work as well as the alleged incident of October 11, 2012 to Dr. Phillips. He told Dr. Phillips he had pain at the base of his right thumb for at least one year prior to the alleged injury of October 11, 2012, but the incident of October 11, 2012 had increased his pain (Rx1). After the examination and his review of the medical records, Dr. Phillips indicated he agreed with Dr. Mahoney that Petitioner's underlying basilar joint arthritis was unrelated to the alleged clamp injury. As noted by Dr. Phillips in his October 12, 2015 report, Petitioner was shown to have swelling and pain at the base of the right thumb after the alleged clamp incident, but no bruising or ecchymosis, despite the fact he was on Coumadin. His radiograph showed no fractures or dislocations. By the time Dr. Mahoney saw Petitioner about 5 weeks later, Petitioner's hand was neither swollen nor warm (Rx1). Dr. Phillips did not believe the specific clamp incident, if it occurred, caused or disrupted the internal infrastructure of the arthritis of Petitioner's thumb or joint. (Rx1).

At the time of his testimony, Dr. Phillips acknowledged he read Dr. Rhode's records as part of the independent medical examination. Dr. Phillips disagreed with Dr. Rhode's claim that Petitioner's CMC joint arthritis is an unusual problem. Dr. Phillips indicated Petitioner's basilar joint arthritis is the second most common form of arthritis seen in a human being in the upper extremities that is only superseded by arthritis of the distal interphalangeal joint (Rx2, p. 23). Dr. Phillips also indicated the CMC joint replacement surgery is the most commonly performed joint replacement surgery in the upper extremity in the United States (Rx2, p. 23). He went on to say this arthritis is very common and very genetic, which is the most common cause of basilar joint arthritis in humans. Dr. Phillips reiterated his agreement with Dr. Mahoney's opinions with regard to causal relation (Rx2, p. 23).

Dr. Phillips also performed an impairment rating of the right thumb on October 12, 2015 (Rx1; Rx2, p. 21). Based upon his training and the use of the AMA Guidelines, Dr. Phillips believed Petitioner had no residual impairment related to the right thumb surgery. Upon Petitioner's return to work in 2014 post surgery, he continued to work full duty for Respondent until a separate alleged incident of March 28, 2016 which is the subject of a different claim.

CONCLUSIONS

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

The Arbitrator finds that the Petitioner's testimony is credible regarding the event of October 11, 2012. Respondent did not provide any evidence to the contrary. The Arbitrator finds that the Petitioner sustained sustain an accident which rose out of the course of his employment on October 11, 2012, when the clamp he was working with struck the base of his right thumb.

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

Petitioner provides a causal relation opinion within the medical records of Dr. Rhode. However, Dr. Rhode did not see Petitioner for initial evaluation until March 13, 2013 and not until Petitioner became dissatisfied with the treatment of Dr. Mahoney who would not causally relate the need for Petitioner's right thumb arthroplasty to either his job duties at work or the alleged specific injury at work using a vice grip on October 11, 2012 (Px4). Dr. Mahoney was clear in the records regarding his understanding of the incident and his reasons for not causally relating treatment to the alleged job duties or the alleged incident (Px4).

Petitioner also saw Dr. Phillips pursuant to section 12 of the Act. He agreed with Dr. Mahoney that the right thumb condition was not due to work activities or the specific work incident as described (Rx2, p. 20). Both Dr. Mahoney and Dr. Phillips disagreed with Dr. Rhode's assessment of the rarity of Petitioner's condition and essentially agreed Petitioner had garden variety osteoarthritis not caused or aggravated by his work activities or the alleged specific incident of October 11, 2012.

The Arbitrator finds the opinions of Dr. Mahoney and Dr. Phillips more persuasive than those of Dr. Rhode. The medical evidence in this case indicates the incident, as described by Petitioner, did not cause or aggravate the condition of the right thumb osteoarthritis.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to establish that his current condition of ill-being is causally related to the accident of October 11, 2012. Benefits are therefore denied.

All other issues are moot.

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

James Marrs,

Petitioner,

vs.

NO: 16 WC 13684

18IWCC0575

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 29, 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.

18IWCC0575

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.

SEP 20 2018

DATED:
TJT:yl
o 9/11/18
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

MARRS, JAMES
Employee/Petitioner

Case# **16WC013684**
12WC042970

CATERPILLAR
Employer/Respondent

18IWCC0575

On 9/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% 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:

5354 STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

5411 CATERPILLER INC
AMANDA WATSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

18IWCC0575

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)

James Marrs
Employee/Petitioner

v.

Caterpillar
Employer/Respondent

Case # 16 WC 13684

Consolidated cases: 12 WC 42970

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 **Peoria**, on **6/20/17**. 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, **3/28/16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,012.80**; the average weekly wage was **$846.40**.

On the date of accident, Petitioner was **60** 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 **$N/A** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to establish that he sustained an accident which arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally related to his employment, benefits are denied. All other issues are moot.

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

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

Michael K. Nowak, Arbitrator

9/25/17
Date

ICArbDec19(b)

SEP 29 2017

18IWCC0575

FINDINGS OF FACT

Petitioner was hired by Respondent on April 25, 2005. Since that time, he has been employed as a welder in Respondent's Building LL in East Peoria, Illinois. In March 2016, he was working on the "ROPS" large weld line. ROPS stands for rollover protection system, which is life support for the D6, D7, D8, D9 and D11 bulldozers produced by Respondent. Petitioner worked on each of the models of bulldozers at various times. In March 2016 Petitioner noticed a worsening of pain in his left hand in the knuckles of his fingers and eventually made his way to Dr. James Williams in Peoria for treatment. Dr. Williams reviewed a job description from Petitioner and provided a causal connection opinion indicating he believed the job description as given to him by Petitioner showed Petitioner's duties for Respondent were at least an aggravation to Petitioner's left middle finger pain, which was diagnosed as osteoarthritis of the left hand (Px4, Px8)

At the time of deposition on July 7, 2016, Dr. Williams was provided with further information regarding Petitioner's duties at work, which would include holding cables, performing grinding, buffing and clearing welding berries. He believed any, or all of these activities could aggravate Petitioner's condition (Px8, p. 18-20). Furthermore, Dr. Williams agreed that Petitioner's removal of bolts, twisting bolts, gripping, grasping and other gripping and grasping could aggravate Petitioner's condition of ill-being necessitating surgery (Px8, p. 18-19). Dr. Williams is recommending an MCP joint replacement of the left middle finger (Px8, p. 16).

Petitioner described his job duties at length at the time of arbitration. He also indicated the job video entered as Respondent's Exhibit 5, was an accurate, but incomplete representation of Petitioner's job duties. Petitioner testified the video only showed the job duties as performed on the D6, not the other bulldozers (T34). Petitioner admitted to Dr. Phillips the setup of the D6 line was the same as the D11 line, however he welded lighter parts on the D6 line (Rx1). Petitioner eventually reported the alleged repetitive trauma to Caterpillar Corporate Medical. He alleged on March 22, 2016, he experienced an increase in sharp, throbbing pain in his left hand while grinding and performing his regular job duties.

Respondent provided the testimony of Paige Smothers, a manufacturing engineer who at the time of Petitioner's alleged accident in March 2016, was assigned to the large weld area in Building LL covering Petitioner's ROPS stations. She had been in large weld in Building LL since June 2015. As part of becoming a manufacturing engineer in the area, she has become an expert in the processes involved in the large weld of D6-D11 bulldozers in the ROPS area (T57). She would spend the majority of her time in March 2016 on the shop floor (T57). She also performed investigations of job stations that could be brought on for safety related issues, quality related issues or capacity issues (T58). The video included as Respondent's Exhibit 5 was taken by Ms. Smothers of the Petitioner performing D6 ROPS tack. The video was actually taken in July or August of 2015, due to a continuous improvement card received from another employee regarding the height of the tack. Ms. Smothers testified the videos are an accurate reflection of the D6 tack process. Ms. Smothers testified that she observed Petitioner working on other D6-D11 tack stations, but she primarily had known him to perform work on the D6's (T61). Ms. Smothers indicated the tack process throughout the D6-D11 stations were pretty much the same, with the size of the frame of the tractors being the greatest difference (T62). The same weld gun is used throughout (T62). Ms. Smothers indicated the D6 frame is the smallest they build, while the D11 is the largest (T62). Ms. Smothers also testified the large weld tack area D6-D11 had not changed significantly in the last 10 years (T65).

Petitioner attended an examination with Dr. Phillips on November 18, 2016, pursuant to section 12 of the Act, to specifically address the left middle finger knuckle and ring finger MP joints that had been giving him problems over some months (Rx1). When Petitioner attended a section 12 examination with Dr. Phillips at the request of Respondent for an unrelated right thumb issue on October 12, 2015, Petitioner complained of left thumb osteoarthritis and middle and ring finger MP joint pain that he also believed may relate to his work activities (Rx1). An x-ray taken on October 12, 2015 by Dr. Phillips showed severe end stage hypertrophic left basilar joint arthritis with joint space narrowing and subluxation of the first metacarpal on the trapezium with massive hypertrophic osteophytes. At the time of the November 18, 2016 independent medical examination, Dr. Phillips again indicated Petitioner had complained of pain in his left thumb and left hand when he saw Petitioner on October 12, 2015. A similar occupational history given to Dr. Phillips on October 12, 2015 was given to him on November 18, 2016. This included the previously described welding job duties. Mr. Marrs indicated a gradual worsening of his left hand pain since seeing Dr. Phillips on October 12, 2015. While the pain in his left thumb was less severe, he described pain over the dorsal aspect of the index, middle and ring fingers. He told Dr. Phillips his pain had started many years ago. He denied acute trauma to the left hand (Rx1). Petitioner alleged rather than heavy activities at work, he felt the "repetitive motion at work" had caused the arthritis in his left hand (Rx1).

The occupational history Petitioner gave to Dr. Phillips on November 18, 2016 indicates he uses his welder with his right hand and supports it with his left. He works with metal pieces to make ROPS, as previously described. He loosens and tightens bolts and uses a hoist to move metal parts as well as using a clamp, primarily with his right hand. For the November 18, 2016 examination, Dr. Phillips was also forwarded a job duty video showing Petitioner's job duties in the ROPS tack area and, as described above, in the D6 area. Dr. Phillips found Petitioner had arthritic symptoms in his left hand and had those symptoms for many years, as shown by his previous independent medical examination and as described by Petitioner on the date of the exam. Dr. Phillips indicated he agreed with Dr. Mahoney's 2013 medical records (Px4), in that Mr. Marrs' bilateral hand arthritis is degenerative in nature and unrelated to his work activities. He specifically disagreed with Dr. Williams' assessment that any gripping, pinching or pulling caused the arthritis. Dr. Phillips stated arthritic changes in the basilar joint of the thumb, as well as in the hand, when degenerative in nature are genetically predetermined. He noted "activities do not affect the arthritis" (Rx1). Radiographs performed on November 18, 2016 supported the diagnosis of severe end stage osteoarthritis of the first CMC joint of the left thumb and MP joint arthritis of the thumb. Petitioner also had significant arthritic changes in the left middle finger, greater than the index and ring finger MP joints of the left hand (Rx1).

Dr. Phillips testified he performed a Jamar dynamometer grip test on both Petitioner's right and left side (Rx2, p. 37). Dr. Phillips indicated Petitioner's grip strength shown on the dynamometer of the left side was 14 and 10 pounds and this was significantly diminished compared to when he first saw Petitioner on October 12, 2015 (Rx2, p. 37-38). With regard to comparison of the radiographs from October 2015 until November 2016, Dr. Phillips was only able to compare the wrist, or the basilar joint, that was also shown on the x-ray of the left wrist. Dr. Phillips indicated the level of arthritis in the left hand could not have been more advanced than it was as shown in October 2015, because it was end stage. He felt it was essentially the same (Rx2, p. 39). Dr. Phillips agreed that Petitioner has degenerative arthritis of his left thumb and also of his left hand, mostly in his middle finger, but also to a lesser extent in the index and ring fingers (Rx2, p. 40).

Dr. Phillips did not believe Petitioner's job duties caused, aggravated or exacerbated the arthritic condition of Petitioner's left middle finger, left thumb or left hand. In addition, Dr. Phillips pointed out he had reviewed the job video entered as Respondent's Exhibit 5 and indicated his review of the video only reinforced his opinion that the job duties did not cause, aggravate or exacerbate the arthritic conditions existing in Petitioner's left hand. Dr. Phillips went on to state Petitioner's arthritis is common and very genetic in nature (Rx2, p. 41). Dr. Phillips believed the middle finger being an affected joint, as it is essentially a protected joint from activity, was further proof this was genetic arthritis (Rx2, p. 41). Dr. Phillips also pointed out the arthritis is affecting Petitioner bilaterally, which is a sign of a genetically predisposed condition (Rx2, p. 43).

CONCLUSIONS

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

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

Testimony provided at the time of trial indicates no significant dispute with regard to Petitioner's job duties as a welder in Building LL of Respondent's East Peoria, IL facility. Although Petitioner testified he had the same essential job since starting work for Respondent in 2005, it appears from the Caterpillar medical records and Petitioner's admission to Dr. Phillips, he was switched from primarily working on the D11 line to the D6 line in September 2012. There is a medical opinion dispute between Dr. Phillips and Dr. Williams.

Dr. Williams testified with regard to Petitioner's job duties and the causal relation of Petitioner's welding job duties to the current condition of his left hand, specifically the arthritis existing in various fingers in the left hand. Dr. Williams believes Petitioner's work duties, at the very least, aggravated the arthritic condition and caused the need for the surgery he has recommended.

Dr. Phillips' exposure to Petitioner goes back to October 12, 2015, when he primarily saw Petitioner for an unrelated right thumb condition. However, at that time, Petitioner was already complaining of pain in his left thumb and fingers and a radiograph of Petitioner's left wrist on October 12, 2015 indicated end stage arthritis already existed in the left basilar joint. In fact, radiographs taken at a later IME of November 18, 2016 were essentially no different of the basilar left thumb joint due to the end stage nature of the arthritis. Petitioner reported to both Dr. Williams and Dr. Phillips he had been suffering from left hand pain for months that had gradually worsened.

There is a fundamental disagreement between Dr. Williams and Dr. Phillips with regard to the ability of Petitioner's job duties to fundamentally change the degenerative arthritic condition and hasten the need for treatment. Dr. Williams believes Petitioner's hand arthritis was aggravated by his welding duties and Dr. Phillips stands firmly behind the notion Petitioner's arthritic hand condition is genetic in nature. Dr. Phillips believes Petitioner is predisposed to the condition and his job activities did not affect the arthritis condition that is the ultimate cause for the need for additional treatment (Rx2, p. 59).

Based upon the bilateral nature of Petitioner's condition, as evidenced in the medical records the Arbitrator finds Dr. Phillips' opinions more persuasive.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to establish that he sustained an accident which arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally related to his employment. Benefits are, therefore denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wiley Moore,

Petitioner,

vs.

NO: 13 WC 39970

18IWCC0576

Gleeson Asphalt, Inc.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission following the remand Order by Judge David W. Dugan of the Circuit Court Third Judicial Circuit Madison County, Illinois dated September 11, 2017 and Corrected Order dated October 12, 2017 directing that "... this matter be remanded to the Illinois Workers' Compensation Commission for a determination of whether there existed an agreement or stipulation for the admission of any part of the medical records contained in Petitioner's Exhibit #3, or whether such records are admissible otherwise, and for further proceedings consistent with this order." Upon consideration of the above remand order, the Commission finds that no such agreement existed between the parties as to the admission of PX3, and that it was not otherwise admissible, for the reasons stated below.

The Commission incorporates, by reference herein, the findings of fact and conclusions of law contained in the previous decisions issued in this matter.

The Commission notes that the Arbitrator, on the record, rejected the medical bills and records submitted at PX3. (T.16). Respondent had objected to the record in question given that it was not certified or subpoenaed pursuant to §16 of the Act. (T.12). The Commission subsequently affirmed and adopted the Arbitrator's decision, including the Arbitrator's ruling on the admission of this exhibit, with one Commissioner dissenting.

Judge Dugan's concerns appear to go to the question of whether or not the parties had agreed or stipulated to the admission of PX3, or whether said exhibit was otherwise admissible, regardless of whether or not it was certified or obtained via subpoena.

18IWCC0576

Upon consideration of the matter, the Commission finds that the record is devoid of any document or verbal agreement that would specifically allow PX3 into evidence. And while there was some discussion between the parties during the course of Dr. Lehman's deposition as to some of the records in question, there is a decided lack of clarity, as Judge Dugan noted, as to the parties' intention along these lines, much less any clear agreement to admit same as PX3.

Along these lines, the Commission notes the following excerpts from the deposition of Dr. Lehman:

After being shown various records by defense counsel, Petitioner's attorney noted "... I will stipulate that all those records as listed on the front page of the doctor's Exhibit 2, medical records review, are contained in his report if that helps you." (RX1, p.15). When defense counsel subsequently moved to admit Lehman Dep. Exhibits 3 through 9 into evidence, Petitioner's attorney noted "I don't have any objections to admission of the medical records, but I object on the basis of relevance, but subject to that, go ahead." (RX1, pp.20-21). Later still, Petitioner's attorney stated, in response to an objection, that "[t]his is cross-examination, sir. And you are the one who put these records and this report [of Dr. Lehman] into the evidence. And everyone [sic] of these records is fair game for cross." (RX1, p.65). Finally, when defense counsel moved to admit Dr. Purvines' records at Lehman Dep. Exhibits 10 through 12, Petitioner's attorney noted "I'm going to agree for all the records – I think you can even do them at the hearing – are all fair game. So I don't have any objection to the records coming in. I'm going to preserve my relevance objection to a couple of them." (RX1, pp.87-88).

Thus, while Petitioner's counsel appears to have had no objection to certain medical records going into evidence as part of Dr. Lehman's deposition, and may have even assumed that these and other medical records would ultimately be going into evidence at the time of trial, there is absolutely no evidence to suggest that Respondent's counsel stipulated to any records being admitted into evidence other than those offered at the time of the deposition. And while there is no doubt some of the same records offered at the time of Dr. Lehman's deposition were the same as those offered as part of PX3, one cannot simply assume that they were one and the same.

Furthermore, the Commission finds it significant that during the course of these proceedings, both at the time of arbitration and on review, Petitioner's counsel did not claim that there was an agreement or stipulation between the parties as to PX3, only that the records were relied upon by Dr. Lehman as part of his testimony and that if PX3 were not allowed into evidence "... you should have to strike Dr. Lehman's deposition as hearsay because he's testifying on records that are hearsay and if they're not admissible for this hearing they're not admissible for his deposition and I would move to strike his deposition." (T.12-13). The Commission believes that if there had been such an agreement, Petitioner's counsel would have claimed as much, and Respondent's counsel would have been asked to confirm or deny such a stipulation. As it was, Petitioner never made such an allegation.

Thus, the Commission sees no tangible evidence that Respondent ever stipulated to the admission of PX3.

18IWCC0576

As far as whether the exhibit is otherwise admissible, the Commission notes in the case of *National Wrecking Co. v. Industrial Commisison (Velasquez)*, 352 Ill. App. 3d 561; 816 N.E.2d 722; 287 Ill. Dec. 755 (1st Dist. 2004), the appellate court ruled that hospital records were not inherently reliable and that "... the reasoning of *Fencl-Tufo* does not apply to certification issues under Section 16 of the Act." The court noted that "[a]lthough the legislature has made it easier to introduce hospital records during workers' compensation proceedings, the language and purpose of section 16 demonstrate that the legislature intended certification to be a minimum foundational requirement that must be satisfied before the records may be admitted 'without any further proof.' It would be inappropriate for this court to recognize a potential means of bypassing section 16 and the rules of evidence, thereby eliminating the foundational requirement altogether." *National Wrecking Co.*, 816 N.E.2d 727-28. The court also pointed out that "[t]he *Fencl Tufo* court specifically noted that the employer objected to the hearsay nature of the evidence and not to any lack of certification pursuant to Section 16." *Id.*, at 728; citing *Fencl Tufo*, 169 Ill. App. 3d at 514.

Thus, at a minimum, Petitioner was required to adhere to the dictates of §16 regarding the receipt of medical records via subpoena or by certification. The fact that some of these records may have been admitted elsewhere is of no matter, and is no justification to admit an exhibit that also may include documents that were not. As a result, the Commission finds that the Arbitrator properly rejected PX3 based on Petitioner's failure to show that said records were certified by the provider or received in response to a subpoena, and that there is no evidence to show that the parties agreed or stipulated to said records going into evidence as PX3.

However, the Commission wishes to point out that some of the records intended to be admitted as part of PX3 were in fact admitted into evidence at the time of Dr. Lehman's deposition (RX1, Lehman Dep. Exh.3-12), and that similarly several bills and accompanying medical records found in PX3 were admitted without objection as part of PX1 and PX4 (Dr. Purvines' dep.).

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

DATED: SEP 20 2018
o:8/7/18
TJT/pmo
51

Michael J. Brennan

Kevin W. Lamborn

SPECIALLY CONCURRING

I concur as to the above finding on remand that there is no evidence that the parties stipulated to the admission of PX3, or that the exhibit in question was otherwise admissible in and

of itself. However, I write separately to reiterate my opinion, stated in my previous dissent, that Petitioner proved by a preponderance of the credible evidence that his current condition of ill-being with respect to his neck, right shoulder, and right arm is causally related to his November 2013 accident. As a result, I believe that the Arbitrator erred in denying compensation, and would have awarded benefits accordingly.

Thomas J. Tyrrell

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

Michelle Johnson,

Petitioner,

18IWCC0577

vs.

NO: 17 WC 8209

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, causal connection, evidence and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 18, 2018, 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.

18IWCC0577

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: SEP 21 2018
O9/20/18
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-1) ARBITRATOR DECISION

18IWCC0577

JOHNSON, MICHELLE
Employee/Petitioner

Case# **17WC008209**

CITY OF CHICAGO
Employer/Respondent

On 7/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 718.00 for the estimated cost of the arbitration transcript and attaches a copy of the check to the Petition; and

3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 2.14% 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:

0391 HEALY SCANLON
JACK CANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0010 CITY OF CHICAGO
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

18IWCC0577

18IWCC0577

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-1)

Michelle Johnson
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **17** WC **08209**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **4/17/2018**. Respondent filed a *Response* on **4/18/2018**. The Honorable **George Andros**, Arbitrator of the Commission, held a pretrial conference on **5/10/2018**, and a trial on **5/18/2018** in the city of **Chicago**. 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, **2/9/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,574.40**; the average weekly wage was **$854.03**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$20,335.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$6,750.78 TTD award** for other benefits, for a total credit of **$27,085.78**.

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

ORDER

Respondent shall pay the Petitioner temporary total disability benefits of $569.35 per week for 55 weeks commencing April 18, 2017 through May 18, 2018. Respondent shall receive a credit for temporary total disability paid through January 2, 2018 pursuant to stipulation by the parties.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter $ or the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

#001 George Andros _____ July 17, 2018

Signature of Arbitrator Date

JUL 18 2018

STATEMENT OF FACTS & CONCLUSION OF LAW 178209

18IWCC0577

PROCEDURAL HISTORY

A previous 19(b) hearing was held on April 27, 2017. The decision was issued on May 17, 2017. The Arbitrator found the Petitioner suffered a work related injury which arose out of and in the course of her employment. The Arbitrator further found that the Petitioner's current condition of ill-being to her neck, left shoulder and left foot was causally related to the Petitioner's work related injury. The Arbitrator found that the Petitioner was temporary and totally disabled from February 10, 2017 to April 27, 2017. The decision was not reviewed.

FINDINGS OF FACT

MEDICAL

The Petitioner was seeing Dr. Robert Strugala at Midland Orthopedic at the time of the previous 19(b) hearing. The Petitioner was referred to Dr. Strugala by Mercy Works, Respondent's approved clinic. The latest note from Midland Orthopedic presented at the previous hearing kept the Petitioner off work through June 1, 2017.

The Petitioner followed up with Dr. Strugala on July 25, 2017. She had an MRI of the cervical spine on July 12, 2017 which revealed:

1. Broad based posterior protrusion at C5-6 causing moderate formaminal and central canal stenosis.
2. Broad-based posterior protrusion at C4-5 causing mild formaminal and central canal stenosis.
3. Broad-based posterior protrusion at C3-4 causing mild formaminal and central canal stenosis.
4. Shallow bulge at C3-4.

5. Multilevel spondylosis exacerbating foraminal/canal stenosis from C3-7. (PEX#3, pp. 11 & 12)

18IWCC0577

The Petitioner continued to have neck and left shoulder pain. Dr. Strugala did not return her to work. He recommended a consultation with Anesthesiology Pain Management. Margaret Power of Coventry was cc'd on the progress note. (PEX#3, pp. 5 & 15)

The Petitioner had similar complaints when returning to Dr. Strugala on August 15, 2017 and also had left foot complaints. The pain management consult had not been approved. Dr. Strugala referred the Petitioner once again for pain management, kept her off work, and once again cc'd Margaret Power of Coventry. (PEX#3, pg. 6) On October 11, 2017 the physician assistant at Midland Orthopedic kept the Petitioner off work. (PEX#3, pg. 16)

The Petitioner saw Dr. Strugala on November 2, 2017. She had worsening complaints of neck pain and pain into the left shoulder. The pain management consult still had not been authorized. Dr. Strugala injected Depo Medrol 40mg/ml, 1cc and 2% Lidocaine 5cc into Petitioner's left shoulder. Dr. Strugala recommended pain management a third time and once again cc'd Margaret Power of Coventry. (PEX#3, pg. 8)

The Petitioner returned to Dr. Strugala on November 16, 2017. She reported her left shoulder pain was diminished since the injection but her neck pain continued and she had intermittent left foot pain. Pain management had not been authorized. Dr. Strugala noted the Petitioner had an upcoming Section 12 exam scheduled for December 5, 2017. Dr. Strugala continued to recommend pain management. He also recommended an MRI of the left foot and kept the Petitioner off work. (PEX#3, pg.9)

The Petitioner returned to Dr. Strugala on December 14, 2017 with continued neck, left shoulder and left foot pain. Dr. Strugala had the same recommendations and again cc'd Margaret Power of Coventry. He did not return the Petitioner to work. (PEX#3, pg.10)

18IWCC0577

An FMLA report form containing the Petitioner's information and signed by Dr. Strugala on January 9, 2018 has the Petitioner off work from March 16, 2017 to March 19, 2018 when she can return to work light duty due to neck and left shoulder pain due to a fall and contains the referral for pain management. (PEX#3, pp. 22 – 25)

A Midland Orthopedic note on March 27, 2018 from physician assistant Jessica B. Rizzo has the Petitioner off work due to cervical disc disorder unspecified mid-cervical region and impingement syndrome of the left shoulder with an estimated return to work date of April 16, 2018. (PEX#3, pg.26)

An April 6, 2018 note from Dr. Robert Strugala notes the Petitioner continues with neck, left shoulder and intermittent left foot pain with ambulation. Dr. Strugala recommended an MRI of the left shoulder and left foot, once again recommended pain management, placed the Petitioner on light duty and ordered her to follow up imaging studies. Margaret Powers of Coventry was cc'd on the report. (PEX#3, pg.28)

The light duty note says sedentary work only, limited use of affected extremity. No overhead lifting/working. No squatting, crawling, kneeling, no prolonged walking. No prolonged standing. (PEX#3, pg.29) Wanda Bates, the Respondent's representative at trial, testified that there is no light duty available for the Petitioner.

On December 5, 2017, the Petitioner reported for a Section 12 examination with Dr. Kenneth Candido. The Petitioner testified that she received a phone call from Wanda Bates, employment administrator for the Respondent, advising her to report to her to transition to return to work full duty.

The Petitioner reported to Ms. Bates the next day. The Petitioner testified that she reported expecting to be returned to work. The Petitioner testified that she was told she needed a full duty release from her treating physician in order to return to work. The Petitioner was given a FMLA form for her doctor to fill out. Dr. Strugala signed the form keeping the Petitioner off work. The Petitioner testified she believed she needed this form to protect her job and health insurance. The Petitioner received a letter from the Respondent dated January 11, 2018. The letter says: The Petitioner's temporary total disability benefits are suspended as of January 3, 2018. It further says "The decision to suspend your benefits will be reconsidered if, within 10 days, you provide a basis for said reconsideration, supported by such proof as may be appropriate. (REX#2)

Ms. Bates testified as the representative for Respondent. Ms. Bates agreed that the Petitioner was compliant and showed up to return to work at the time and place ordered by Ms. Bates. Ms. Bates testified that there are approximately 16 different forms that are needed to be completed in order for the Petitioner to return to work. Ms. Bates admitted she did not give the Petitioner any of these forms. Ms. Bates agreed that the Petitioner's failure to receive the forms and have them filled out could have just been due to confusion. Ms. Bates gave the Petitioner FMLA forms. Ms. Bates testified that the Petitioner told her she could not return to work due to her doctor's orders. Ms. Bates testified that any prior Section 12 return to work was rendered void and redundant once the treating doctor signed the FMLA form on January 9, 2018.

The Petitioner's doctor signed the FMLA form on January 9. 2018. The Petitioner returned the form to Ms. Bates on January 18, 2018. From that point forward, the Petitioner could not return to work under the recommendations of the Section 12 examiner according to Ms. Bates.

CONCLUSIONS OF LAW

OBJECTIONS

The Arbitrator ruled on a number of objections raised by each party and addresses them in order of presentation.

Respondent's objection to Petitioner's Exhibit #1 which is a single medical note from the Petitioner's treating doctor, Dr. Robert Strugala is sustained as it is not accompanied by a certification, as required by Section 16 of the Act. Petitioner's Exhibit #3 contains the appropriate certification and has the same medical note

Respondent's objection to Petitioner's Exhibit #3 is overruled. Petitioner's Exhibit #3 are the records of Midland Orthopedic. The records contain the appropriate certificate of authenticity and are therefore presumed admissible under Section 16 of the Act. The Respondent has not rebutted the presumption.

The Petitioner's hearsay objection to Respondent's Exhibit #1, which is a Section 12 report from Dr. Kenneth Candido, is sustained. The Arbitrator does not rule on the Petitioner's objections that the report is inadmissible due to the report containing permanency opinions in violation of Section 19(b1) rules. The Arbitrator also makes no ruling on the Petitioner's objection that Dr. Candido is not listed as a witness as required by the Respondent's response to the 19(b-1) Petition.

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

The Arbitrator previously heard this matter on a 19(b) on April 27, 2017 and found the Petitioner suffered a work related injury which arose out of and in the course of her employment. The Arbitrator also found that the Petitioner's current condition of ill-being is causally connected to her injury and that the Petitioner was owed temporary total disability for 11 6/7 weeks from February 10, 2017 to April 27, 2017. The concept of the Law of the Case applies.

The Petitioner last testified on April 27, 2017. The only admissible medical evidence are the records from Dr. Robert Strugala of Midland Orthopedic. The records since then show that Dr. Strugala continues to keep the Petitioner completely off work through April 6, 2018 and on light duty as of April 6, 2018 due to a combination of neck, left shoulder and left foot pain. Ms. Bates, the City of Chicago representative, testified that the Respondent does not have light duty.

Based on the totality of the evidence, the Arbitrator finds that the Petitioner's current condition of ill-being is causally connected to her injury.

TEMPORARY TOTAL DISABILITY

The undisputed fact is that the Petitioner was given a time and place to return back to work, reported at said time and place as required and, for what can be best described as a breakdown in communication, never received the appropriate paperwork that would allow her to return to work. Any chance of Petitioner being able to return to work ended when Dr. Strugala signed the FMLA forms January 9, 2018 according to Ms. Bates.

Moreover, Ms. Bates agreed that she never actually gave the Petitioner the necessary paperwork that would allow the Petitioner to return to work even though both Ms. Bates and the Petitioner agreed that the Petitioner reported to Ms. Bates at the time and place required. Ms. Bates agreed that the Petitioner's failure to receive and execute the appropriate return to work paperwork could be due to confusion. Even if the Respondent's Section 12 was admissible, Ms. Bates admitted that the subsequent FMLA form signed by Dr. Strugala renders it null and void as of January 9, 2018.

The only admissible medical evidence has the Petitioner off work or on light duty from the date she last testified April 27, 2017 through the date of the 19 (b-1) hearing May 18, 2018. The Respondent admitted that they did not have light duty available.

Based upon the totality of the evidence, the Arbitrator finds that the Respondent shall pay the Petitioner & his her attorney of record the temporary total disability benefits of $569.35 a week for a total of 55 weeks as the Petitioner was temporary totally disabled from April 18, 2017 through May 18, 2018. The parties stipulated at hearing Petitioner had received temporary total disability up until January 2, 2018. The Respondent shall receive a credit for this period of time.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SAMUEL MOODY,

Petitioner,

vs. NO: 16 WC 30448

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION,

18IWCC0578

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, notice, causation, medical expenses, and prospective medical treatment, 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 on March 23, 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.

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

18IWCC0578

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

DATED: SEP 25 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 080118
49

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

MOODY, SAMUEL
Employee/Petitioner

Case# **16WC030448**

13WC033482

IL DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0578

On 3/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0724 JANSSEN LAW CENTER
MATTHEW A BREWER
333 MAIN ST
PEORIA, IL 61602

5260 ASSISTANT ATTORNEY GENERAL
KRISTINA D DION
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

MAR 23 2017

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

18IWCC0578

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)

Samuel Moody
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **16** WC **30448**

Consolidated cases: **13 WC 33482**

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 **Peoria**, on **December 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/25/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is not* causally related to the accident, but causally related to Petitioner's accident of 10/17/2012.

In the year preceding the injury, Petitioner earned **$53,199.00**; the average weekly wage was **$1,023.06**.

On the date of accident, Petitioner was **49** years of age, *married* with **1** dependent children.

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

Respondent shall be given a credit of **$0.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** 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 accident of 10/25/2012 was merely a transient exacerbation of the injuries sustained in the accident of 10/17/2012. Benefits are therefore denied.

Benefits are, however awarded in case 13 WC 33482 (date of accident 10/17/2012).

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

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

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

Michael k. Nowak, Arbitrator

3/18/17
Date

ICArbDec19(b)

MAR 2 3 2017

FINDINGS OF FACT

Petitioner alleged he sustained injuries to his right knee on October 17, 2012, and October 25, 2012. Petitioner worked for Respondent as a highway maintenance worker and stated his job duties were maintaining highways and roads in the Peoria area. Petitioner's work included tearing out and replacing black top and concrete road surfaces. Petitioner used high pressure hoses, jackhammers and other tools.

Petitioner testified that on October 17, 2012, he was in the process of dismounting one of the work trucks and, when he stepped down, it felt like something ripped in his right knee. Petitioner stated he immediately reported the accident to Mike Wroblewski, his supervisor, who was present at the worksite.

Petitioner stated he continued to work, but that over the next few days, the right knee pain worsened and there was swelling of the right knee. Petitioner completed and signed an "Employee's Notice of Injury" on October 22, 2012, which stated Petitioner had injured his right knee on October 17, 2012, while dismounting a work truck. It also indicated Petitioner did not believe it was serious at first. A "Witness Report" was completed by Michael Wroblewski on October 23, 2012, which stated he did not see Petitioner sustain an injury and Petitioner did not report an injury to him; however, Wroblewski also stated in the report that if Petitioner said he got hurt, he was sure Petitioner did. (RX 2)

Petitioner was seen by Dr. Lashunda Williams, his family physician, on October 22, 2012. According to her record, Petitioner injured his right leg when he stepped out of a truck and felt a "twitch" in the knee. She indicated she was going to refer Petitioner to Dr. Phillips, an orthopedic surgeon. (PX 2)

Petitioner testified he sustained another injury to his right knee on October 25, 2012. Petitioner stated he was shoveling and, when he stepped back onto an area of loose gravel, his right knee gave out on him. Petitioner again informed Mike Wroblewski that he had sustained an injury. Petitioner completed and signed an "Employee's Notice of Injury" on October 25, 2012, which stated that on that day he reinjured his right knee when he slipped on loose gravel and rock while shoveling. Michael Wroblewski completed and signed a "Witness Report" on October 25, 2012, which stated Petitioner lost his footing on a sidewalk that had rock and sand on it and hurt his right knee. (RX 1)

On October 25, 2012, Petitioner was seen by Dr. Williams. According to her record, when Petitioner went to scoop some loose gravel, his right leg gave way and he felt a pulling sensation in his right knee. Dr. Williams again stated she was referring Petitioner to Dr. Phillips. (PX 4)

Petitioner was seen by Dr. Mark Phillips, an orthopedic surgeon, on November 14, 2012. Dr. Phillips' record noted Petitioner had previously undergone right knee surgery in the early 90s, but had been doing well prior to the injury at work. Dr. Phillips ordered an MRI scan and authorized Petitioner to be off work. (PX 9)

Petitioner testified he injured his right knee in 1993 while working out and Dr. Phillips performed arthroscopic surgery. Petitioner stated he fully recovered from the surgery and had no right knee problems until he sustained the injury on October 17, 2012.

Petitioner was, in fact, seen by Dr. Stephen Orlevitch, an orthopedic surgeon, on March 16, 2004, primarily for left knee symptoms. His record noted Petitioner had undergone arthroscopic surgery on the right knee in 1993, and x-rays of the right knee revealed degenerative changes. Examination revealed effusions in both knees; however, the diagnosis and treatment recommendation was in regard to the left knee. (RX 11)

The MRI was performed on November 16, 2012. It revealed a torn medial meniscus, moderate to severe chondromalacia of the medial and lateral compartments, and patellofemoral chondromalacia with severe involvement of the medial aspect of the femoral trochlear groove. (PX 9)

When Dr. Phillips saw Petitioner on November 27, 2012, he reviewed the MRI scan and recommended Petitioner undergo right knee surgery. Dr. Phillips saw Petitioner on December 26, 2012. In his record of that date, he noted Petitioner had injured his right knee on October 17, 2012, while at work when he got out of a truck and twisted his right knee. He also noted Petitioner aggravated the knee a second time while shoveling gravel at work. Dr. Phillips reaffirmed his surgical recommendation. (PX9)

Dr. Phillips performed arthroscopic surgery on January 4, 2013. The procedure consisted of partial medial and lateral meniscectomies, excision of medial patellar plica and excision of osteophytes in the patellar region. (PX9)

Dr. Phillips continued to treat Petitioner after the surgery and he ordered physical therapy and work hardening. Petitioner had some instances in which his right knee buckled. When Dr. Phillips evaluated Petitioner on October 22, 2013, he noted Petitioner had made only "minimal improvement" and stated Petitioner had patellofemoral degenerative joint disease. (PX9)

Petitioner testified he began to have back symptoms in March and April, 2013. He stated his physicians informed him that he was having back pain because of his favoring his injured knee. Petitioner stated the pain was initially in the middle back area but progressed to both the left and right side of his low back.

Petitioner previously sustained a work-related injury to his low back on September 22, 2011, when he was shoveling asphalt. Petitioner testified he recovered from that injury and had no back symptoms from June, 2012, until sometime in April, 2013. On June 7, 2012, Petitioner was evaluated and found to be "medically qualified" to return to work to his job for Respondent. (PX11)

Petitioner testified his back pain also worsened while he was in physical therapy. Dr. Phillips' records did not make any specific reference to Petitioner having back pain or experiencing back symptoms while in physical therapy (PX9). However, Petitioner was seen by Dr. Williams on September 3, 2013, and had complaints of back pain which he attributed to his physical therapy. (PX4)

Petitioner was seen by Dr. Piero Capecci, an orthopedic surgeon, on November 2, 2013. Dr. Capecci previously treated Petitioner for a left hip injury. Petitioner informed Dr. Capecci of his two work-related injuries to his right knee and the treatment he received thereafter. Dr. Capecci stated Petitioner had moderate to severe osteoarthritis of the right knee. He administered an injection into the right knee and stated it was likely Petitioner would require a knee replacement in the future. (PX9)

Dr. Capecci administered three more injections into the right knee in January, 2014, which did not give Petitioner any significant relief from his symptoms. Dr. Capecci saw Petitioner on April 7, 2014, and recommended Petitioner proceed with the total knee replacement surgery. He also authorized Petitioner to be off work until the knee replacement surgery was performed and Petitioner had recovered. (PX9)

Dr. Williams saw Petitioner on April 17, 2014, for a checkup regarding some other medical conditions. At that time, her examination of Petitioner's back was normal and Petitioner had a normal range of motion. (PX4)

Dr. Williams saw Petitioner on November 13, 2014, primarily because of Petitioner's low back symptoms. Dr. Williams referred Petitioner to Dr. Clark Rians, an orthopedic surgeon. (PX4)

Dr. Rians saw Petitioner on December 1, 2014, for low back pain and bilateral foot burning sensations. Dr. Rians ordered an MRI of Petitioner's low back and referred Petitioner to Dr. John Ruff, a podiatrist. (RX12)

The MRI was performed on January 29, 2015. According to Dr. Rians, the MRI revealed some disc protrusions on the right but no central disc herniations. (RX12)

Petitioner testified Dr. Rians referred him to Dr. Jianxun Zhou, for his chronic low back pain. Dr. Zhou examined Petitioner and reviewed the MRI scan. He recommended Petitioner have an EMG to determine if there was any peripheral neuropathy and stated Petitioner should return to his primary physician. (PX6)

Dr. Williams saw Petitioner on April 28, 2015, and June 9, 2015. When seen on June 9, 2015, Petitioner told Dr. Williams his right knee gave out on him which caused him to fall off his porch landing on concrete. Petitioner complained of right knee and low back pain. Dr. Williams then referred Petitioner to Dr. Daniel Mulconrey, an orthopedic surgeon. (PX4)

Dr. Mulconrey saw Petitioner on July 8, 2015, primarily for his low back symptoms. According to his record, Petitioner was uncertain of their origin. Dr. Mulconrey examined Petitioner and reviewed the MRI scan. He recommended Petitioner undergo some epidural injections. (PX7)

Petitioner was seen by Dr. Arnold Sureka who administered epidural injections at left L4 and left L5 levels on August 19 and August 25, 2015. (PX7) Petitioner testified the injections did not help.

Dr. Mulconrey saw Petitioner on December 16, 2015, and he recommended Petitioner undergo a CT scan. Because of Petitioner's inability to work and his continued symptoms, he recommended Petitioner have either ablations or a medial branch block. (PX7)

Dr. Lawrence Li, an orthopedic surgeon, examined Petitioner on May 20, 2014, and May 3, 2016, for his knee and low back conditions, respectively. Both examinations were performed at the request of Respondent.

In regard to his examination of May 20, 2014, Dr. Li reviewed Petitioner's treatment records and the MRIs. According to the history he obtained from Petitioner, Petitioner injured his right knee on October 25, 2012, when he stepped out of a truck and twisted his knee. Dr. Li opined the accident of October 25, 2012, resulted in a worsening of the medial meniscal tear, the treatment was appropriate and that condition had resolved. Dr. Li agreed Petitioner needed a total knee replacement; however, he attributed the need for that surgery to Petitioner's pre-existing osteoarthritis and not the accident of October 25, 2012. (RX3)

In regard to his examination of May 3, 2016, Dr. Li reviewed Petitioner's treatment records. Dr. Li opined Petitioner had spinal stenosis and deferred to Dr. Mulconrey's treatment recommendations. Dr. Li stated there was not a causal relationship between Petitioner's work-related accident and this condition because the records did not reveal Petitioner had sustained a spinal injury on the date of the accident. (RX4)

Dr. Capecci testified by deposition on August 15, 2014. Dr. Capecci testified the meniscal tears were aggravated by the accident of October 17, 2012. He also stated Petitioner required a total knee replacement and that the accident of October 17, 2012, aggravated the underlying arthritic condition that hastened the need for the total knee replacement surgery. (PX2; pp 11-12, 16)

Dr. Mulconrey testified by deposition on June 6, 2016. With regard to Petitioner's low back symptoms, Dr. Mulconrey testified that individuals who have a change in their gait pattern can experience an exacerbation of lumbar pain or arthritis. He also noted Petitioner had, following the knee surgery, used a crutch or cane and that this could have caused an alteration in his gait which caused Petitioner's lumbar pain. (PX3; pp 30-31)

On cross-examination, Dr. Mulconrey agreed that dismounting a truck and sustaining a twisting injury to a knee would not cause a disc bulge. He also stated it was possible Petitioner would need a total knee replacement even if there had been no accident. (PX3; pp 23, 37)

Dr. Li was deposed on two occasions, September 22, 2014, and August 15, 2016. The first deposition was in regard to Petitioner's right knee condition and the second deposition was in regard to Petitioner's low back condition.

In his deposition of September 22, 2014, Dr. Li agreed that the knee surgery performed by Dr. Phillips was causally related to the accident of October 25, 2012. However, Dr. Li testified Petitioner's need for total knee replacement surgery was not related to Petitioner's work-related accident. He stated that once the torn meniscus was removed, any remaining symptoms would be due to the underlying arthritic condition. He disagreed with Dr. Capecci's opinion that the accident aggravated the underlying arthritic condition. (RX5; pp 10-17)

In his deposition of August 15, 2016, he testified Petitioner had degenerative spinal stenosis and there was no causal relationship between it and Petitioner's work accidents. On cross-examination, Dr. Li agreed that a right knee injury could cause one to have an altered gait and it was possible to develop back symptoms as a result thereof. (RX6; pp 32-33, 37-41)

Petitioner testified he still has right knee pain and instability. Petitioner stated he has zero trust in his right knee and said it has given way on him on a number of occasions. Since the knee surgery, Petitioner has regularly used either a crutch or cane to walk. Petitioner does want to proceed with having the total knee replacement surgery. Petitioner also continues to have low back pain and wants to receive treatment for that condition as well.

Michael Wroblewski testified at trial. Wroblewski stated he was Petitioner's supervisor at the time of both accidents. He testified Petitioner reported the accidents of October 17 and October 25, 2012, to him shortly after they occurred. In regard to the accident of October 17, 2012, Wroblewski's testimony was contrary to the "Witness Report" prepared by him on October 22, 2012.

CONCLUSIONS

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

Petitioner testified he sustained an injury to his right knee on October 25, 2012, when he stepped back on an area of loose gravel and his right knee gave out. Petitioner reported the accident to Michael Wroblewski, his supervisor, immediately after its occurrence.

The Arbitrator concludes Petitioner sustained an accident that arose out of and in the course of his employment by Respondent on October 25, 2012.

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

On October 25, 2012, Michael Wroblewski, prepared a "Witness Report" which described the accident of October 25, 2012. At trial, Wroblewski testified Petitioner informed him of the accident on the same day it occurred.

The Arbitrator concludes Petitioner gave notice to Respondent of the accident of October 25, 2012, in a timely manner.

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

Based upon the Arbitrator's conclusion in regard to this issue in 13 WC 33482, the Arbitrator concludes this accident resulted in a transient exacerbation of the injury to the right knee and Petitioner's current conditions of ill-being are related to the accident of October 17, 2012.

All other issues are moot.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SAMUEL MOODY,

Petitioner,

vs. NO: 13 WC 33482

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION,

18IWCC0579

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

The Commission finds that Petitioner met his burden of proof regarding accident. The Commission finds that Petitioner's right knee injury is causally related to his alleged work accident of October 17, 2012, and that he is entitled to medical expenses, temporary total disability benefits, and prospective medical treatment in the form of the right total knee replacement surgery and attendant care recommended by Dr. Piero Capecci. The Commission finds, however, that Petitioner did not prove causal connection in regard to his back injury. The Commission therefore reverses the award for prospective medical treatment as recommended by Dr. Daniel Mulconrey, as well as the award for medical expenses as it relates to treatment for the back.

Petitioner claims to have been injured while dismounting a work truck on 10/17/12. He thought the pain would subside and continued to work, but reported the accident on 10/22/12 when the pain was not subsiding. (Rx2) Petitioner's supervisor completed a work incident report stating

that he did not see Petitioner get injured, but if he said he was hurt, he was. There is no dispute that Petitioner suffered a right knee injury necessitating surgery in 1993, or that Petitioner sustained prior problems related to his back causing him to miss 4 months of work in 2011-12. Additionally, the record is clear that Petitioner suffers from significant problems from osteoarthritis. However, the evidence supports that the work-related accidents aggravated/accelerated Petitioner's need for treatment in the form of a knee replacement.

Petitioner had prior knee surgery in 1993. The records do not support an ongoing issue with Petitioner's knee after that time. Following the October, 2012 incidents, Petitioner sustained lateral and medial meniscus tears. (Px9 11/16/12 MRI report and 1/4/13 operative report) None of Petitioner's treating physicians believed him to be demonstrating symptom magnification nor malingering. Dr. Capecci additionally gave a more credible causation opinion than that rendered by the State's Section 12 examiner, Dr. Li. Dr. Capecci testified that it is his opinion that the right knee replacement of Petitioner might or could have been caused by an aggravation due to the trauma dated October 17, 2012. Although it is possible that Petitioner's knee replacement would have been a natural consequence of the osteoarthritis, the work accidents in October, 2012, aggravated Petitioner's condition, hence resulting in the need for the surgery. The Commission awards prospective medical treatment in the form of the right total knee replacement surgery recommended by Dr. Piero Capecci and the attendant care thereto.

The Commission, however, denies prospective medical treatment for the back, as well as medical expenses regarding the back treatment. Petitioner's records are significant for complaints from spinal stenosis prior to the October 2012 incident. Dr. Li's testimony regarding Petitioner's back pain was more persuasive than that of Petitioner's treating physician, Dr. Mulconrey. Dr. Li testified that an altered gait over time wouldn't necessarily lead to the development of back pain. It depends on the gait, it depends on the specific patient. Lots of people have altered gaits. A minority of people with an altered gait will develop back pain. It's possible that there are still some people that can develop back pain as a result of an altered gait. It could be something that would happen over an extended period of time for the small portion of the population that do experience back pain as a result of an altered gait. (Rx6 pp. 39-41) Dr. Mulconrey's testimony that the alteration in the gait based upon the right knee pain that Petitioner has been experiencing since the October 2012 accident, could be increasing his lumbar pain, simply wasn't persuasive. (Px3 p. 31)

Petitioner underwent a right knee arthroscopy, debridement and partial medial and lateral meniscectomies on January 4, 2013. Petitioner underwent a complicated course of recovery, and Dr. Phillips ultimately released him as MMI as of October 23, 2013. The Commission therefore modifies the duration of temporary total disability to the time frame of January 4, 2013 through October 23, 2013. However, the Commission affirms the Arbitrator's award of temporary total disability from April 7, 2014 through December 16, 2016.

Finally, Petitioner should be awarded medical expenses with regard to the right knee and connected treatment. Petitioner did not prove his case that the back treatment was causally connected to the October, 2012 work incidents, or that the treatment was reasonable and necessary. Medical expenses regarding the back are therefore denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $682.04 per week for a period of 189 3/7 weeks, that being the period of

18IWCC0579

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 reasonable and necessary medical expenses related to the treatment of the right knee, 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 provide and pay for prospective medical care including the total knee replacement surgery recommended by Dr. Piero Capecci, as provided in §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.

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

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

DATED: SEP 25 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 080118
49

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

MOODY, SAMUEL
Employee/Petitioner

Case# **13WC033482**

16WC030448

IL DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0579

On 3/23/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0724 JANSSEN LAW CENTER
MATTHEW A BREWER
333 MAIN ST
PEORIA, IL 61602

5260 ASSISTANT ATTORNEY GENERAL
KRISTINA D DION
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

MAR 23 2017

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

18IWCC0579

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Samuel Moody
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **13** WC **33482**

Consolidated cases: **16 WC 30448**

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 **Peoria**, on **December 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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. [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, **10/17/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$53,199.00**; the average weekly wage was **$1,023.06**.

On the date of accident, Petitioner was **49** years of age, *married* with **1** dependent children.

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

Respondent shall be given a credit of **$50,375.50** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$50,375.50**.

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 of $51,382.55, as set forth in Petitioner's Exhibit 12, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall also authorize and pay for prospective medical care including the total knee replacement surgery recommended by Dr. Piero Capecci and the back treatment recommended by Dr. Daniel Mulconrey, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $682.04 per week for 203 3/7 weeks, commencing November 14, 2012, through January 30, 2014, and April 7, 2014, through December 13, 2016, 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. .

Michael k. Nowak, Arbitrator

3/17/17
Date

ICArbDec19(b)

MAR 2 3 2017

FINDINGS OF FACT

Petitioner alleged he sustained injuries to his right knee on October 17, 2012, and October 25, 2012. Petitioner worked for Respondent as a highway maintenance worker and stated his job duties were maintaining highways and roads in the Peoria area. Petitioner's work included tearing out and replacing black top and concrete road surfaces. Petitioner used high pressure hoses, jackhammers and other tools.

Petitioner testified that on October 17, 2012, he was in the process of dismounting one of the work trucks and, when he stepped down, it felt like something ripped in his right knee. Petitioner stated he immediately reported the accident to Mike Wroblewski, his supervisor, who was present at the worksite.

Petitioner stated he continued to work, but that over the next few days, the right knee pain worsened and there was swelling of the right knee. Petitioner completed and signed an "Employee's Notice of Injury" on October 22, 2012, which stated Petitioner had injured his right knee on October 17, 2012, while dismounting a work truck. It also indicated Petitioner did not believe it was serious at first. A "Witness Report" was completed by Michael Wroblewski on October 23, 2012, which stated he did not see Petitioner sustain an injury and Petitioner did not report an injury to him; however, Wroblewski also stated in the report that if Petitioner said he got hurt, he was sure Petitioner did. (RX 2)

Petitioner was seen by Dr. Lashunda Williams, his family physician, on October 22, 2012. According to her record, Petitioner injured his right leg when he stepped out of a truck and felt a "twitch" in the knee. She indicated she was going to refer Petitioner to Dr. Phillips, an orthopedic surgeon. (PX 2)

Petitioner testified he sustained another injury to his right knee on October 25, 2012. Petitioner stated he was shoveling and, when he stepped back onto an area of loose gravel, his right knee gave out on him. Petitioner again informed Mike Wroblewski that he had sustained an injury. Petitioner completed and signed an "Employee's Notice of Injury" on October 25, 2012, which stated that on that day he reinjured his right knee when he slipped on loose gravel and rock while shoveling. Michael Wroblewski completed and signed a "Witness Report" on October 25, 2012, which stated Petitioner lost his footing on a sidewalk that had rock and sand on it and hurt his right knee. (RX 1)

On October 25, 2012, Petitioner was seen by Dr. Williams. According to her record, when Petitioner went to scoop some loose gravel, his right leg gave way and he felt a pulling sensation in his right knee. Dr. Williams again stated she was referring Petitioner to Dr. Phillips. (PX 4)

Petitioner was seen by Dr. Mark Phillips, an orthopedic surgeon, on November 14, 2012. Dr. Phillips' record noted Petitioner had previously undergone right knee surgery in the early 90s, but had been doing well prior to the injury at work. Dr. Phillips ordered an MRI scan and authorized Petitioner to be off work. (PX 9)

Petitioner testified he injured his right knee in 1993 while working out and Dr. Phillips performed arthroscopic surgery. Petitioner stated he fully recovered from the surgery and had no right knee problems until he sustained the injury on October 17, 2012.

Petitioner was, in fact, seen by Dr. Stephen Orlevitch, an orthopedic surgeon, on March 16, 2004, primarily for left knee symptoms. His record noted Petitioner had undergone arthroscopic surgery on the right knee in 1993, and x-rays of the right knee revealed degenerative changes. Examination revealed effusions in both knees; however, the diagnosis and treatment recommendation was in regard to the left knee. (RX 11)

The MRI was performed on November 16, 2012. It revealed a torn medial meniscus, moderate to severe chondromalacia of the medial and lateral compartments, and patellofemoral chondromalacia with severe involvement of the medial aspect of the femoral trochlear groove. (PX 9)

When Dr. Phillips saw Petitioner on November 27, 2012, he reviewed the MRI scan and recommended Petitioner undergo right knee surgery. Dr. Phillips saw Petitioner on December 26, 2012. In his record of that date, he noted Petitioner had injured his right knee on October 17, 2012, while at work when he got out of a truck and twisted his right knee. He also noted Petitioner aggravated the knee a second time while shoveling gravel at work. Dr. Phillips reaffirmed his surgical recommendation. (PX9)

Dr. Phillips performed arthroscopic surgery on January 4, 2013. The procedure consisted of partial medial and lateral meniscectomies, excision of medial patellar plica and excision of osteophytes in the patellar region. (PX9)

Dr. Phillips continued to treat Petitioner after the surgery and he ordered physical therapy and work hardening. Petitioner had some instances in which his right knee buckled. When Dr. Phillips evaluated Petitioner on October 22, 2013, he noted Petitioner had made only "minimal improvement" and stated Petitioner had patellofemoral degenerative joint disease. (PX9)

Petitioner testified he began to have back symptoms in March and April, 2013. He stated his physicians informed him that he was having back pain because of his favoring his injured knee. Petitioner stated the pain was initially in the middle back area but progressed to both the left and right side of his low back.

Petitioner previously sustained a work-related injury to his low back on September 22, 2011, when he was shoveling asphalt. Petitioner testified he recovered from that injury and had no back symptoms from June, 2012, until sometime in April, 2013. On June 7, 2012, Petitioner was evaluated and found to be "medically qualified" to return to work to his job for Respondent. (PX11)

Petitioner testified his back pain also worsened while he was in physical therapy. Dr. Phillips' records did not make any specific reference to Petitioner having back pain or experiencing back symptoms while in physical therapy (PX9). However, Petitioner was seen by Dr. Williams on September 3, 2013, and had complaints of back pain which he attributed to his physical therapy. (PX4)

Petitioner was seen by Dr. Piero Capecci, an orthopedic surgeon, on November 2, 2013. Dr. Capecci previously treated Petitioner for a left hip injury. Petitioner informed Dr. Capecci of his two work-related injuries to his right knee and the treatment he received thereafter. Dr. Capecci stated Petitioner had moderate to severe osteoarthritis of the right knee. He administered an injection into the right knee and stated it was likely Petitioner would require a knee replacement in the future. (PX9)

Dr. Capecci administered three more injections into the right knee in January, 2014, which did not give Petitioner any significant relief from his symptoms. Dr. Capecci saw Petitioner on April 7, 2014, and recommended Petitioner proceed with the total knee replacement surgery. He also authorized Petitioner to be off work until the knee replacement surgery was performed and Petitioner had recovered. (PX9)

Dr. Williams saw Petitioner on April 17, 2014, for a checkup regarding some other medical conditions. At that time, her examination of Petitioner's back was normal and Petitioner had a normal range of motion. (PX4)

Dr. Williams saw Petitioner on November 13, 2014, primarily because of Petitioner's low back symptoms. Dr. Williams referred Petitioner to Dr. Clark Rians, an orthopedic surgeon. (PX4)

Dr. Rians saw Petitioner on December 1, 2014, for low back pain and bilateral foot burning sensations. Dr. Rians ordered an MRI of Petitioner's low back and referred Petitioner to Dr. John Ruff, a podiatrist. (RX12)

The MRI was performed on January 29, 2015. According to Dr. Rians, the MRI revealed some disc protrusions on the right but no central disc herniations. (RX12)

Petitioner testified Dr. Rians referred him to Dr. Jianxun Zhou, for his chronic low back pain. Dr. Zhou examined Petitioner and reviewed the MRI scan. He recommended Petitioner have an EMG to determine if there was any peripheral neuropathy and stated Petitioner should return to his primary physician. (PX6)

Dr. Williams saw Petitioner on April 28, 2015, and June 9, 2015. When seen on June 9, 2015, Petitioner told Dr. Williams his right knee gave out on him which caused him to fall off his porch landing on concrete. Petitioner complained of right knee and low back pain. Dr. Williams then referred Petitioner to Dr. Daniel Mulconrey, an orthopedic surgeon. (PX4)

Dr. Mulconrey saw Petitioner on July 8, 2015, primarily for his low back symptoms. According to his record, Petitioner was uncertain of their origin. Dr. Mulconrey examined Petitioner and reviewed the MRI scan. He recommended Petitioner undergo some epidural injections. (PX7)

Petitioner was seen by Dr. Arnold Sureka who administered epidural injections at left L4 and left L5 levels on August 19 and August 25, 2015. (PX7) Petitioner testified the injections did not help.

Dr. Mulconrey saw Petitioner on December 16, 2015, and he recommended Petitioner undergo a CT scan. Because of Petitioner's inability to work and his continued symptoms, he recommended Petitioner have either ablations or a medial branch block. (PX7)

Dr. Lawrence Li, an orthopedic surgeon, examined Petitioner on May 20, 2014, and May 3, 2016, for his knee and low back conditions, respectively. Both examinations were performed at the request of Respondent.

In regard to his examination of May 20, 2014, Dr. Li reviewed Petitioner's treatment records and the MRIs. According to the history he obtained from Petitioner, Petitioner injured his right knee on October 25, 2012, when he stepped out of a truck and twisted his knee. Dr. Li opined the accident of October 25, 2012, resulted in a worsening of the medial meniscal tear, the treatment was appropriate and that condition had resolved. Dr. Li agreed Petitioner needed a total knee replacement; however, he attributed the need for that surgery to Petitioner's pre-existing osteoarthritis and not the accident of October 25, 2012. (RX3)

In regard to his examination of May 3, 2016, Dr. Li reviewed Petitioner's treatment records. Dr. Li opined Petitioner had spinal stenosis and deferred to Dr. Mulconrey's treatment recommendations. Dr. Li stated there was not a causal relationship between Petitioner's work-related accident and this condition because the records did not reveal Petitioner had sustained a spinal injury on the date of the accident. (RX4)

Dr. Capecci testified by deposition on August 15, 2014. Dr. Capecci testified the meniscal tears were aggravated by the accident of October 17, 2012. He also stated Petitioner required a total knee replacement and that the accident of October 17, 2012, aggravated the underlying arthritic condition that hastened the need for the total knee replacement surgery. (PX2; pp 11-12, 16)

Dr. Mulconrey testified by deposition on June 6, 2016. With regard to Petitioner's low back symptoms, Dr. Mulconrey testified that individuals who have a change in their gait pattern can experience an exacerbation of lumbar pain or arthritis. He also noted Petitioner had, following the knee surgery, used a crutch or cane and that this could have caused an alteration in his gait which caused Petitioner's lumbar pain. (PX3; pp 30-31)

On cross-examination, Dr. Mulconrey agreed that dismounting a truck and sustaining a twisting injury to a knee would not cause a disc bulge. He also stated it was possible Petitioner would need a total knee replacement even if there had been no accident. (PX3; pp 23, 37)

Dr. Li was deposed on two occasions, September 22, 2014, and August 15, 2016. The first deposition was in regard to Petitioner's right knee condition and the second deposition was in regard to Petitioner's low back condition.

In his deposition of September 22, 2014, Dr. Li agreed that the knee surgery performed by Dr. Phillips was causally related to the accident of October 25, 2012. However, Dr. Li testified Petitioner's need for total knee replacement surgery was not related to Petitioner's work-related accident. He stated that once the torn meniscus was removed, any remaining symptoms would be due to the underlying arthritic condition. He disagreed with Dr. Capecci's opinion that the accident aggravated the underlying arthritic condition. (RX5; pp 10-17)

In his deposition of August 15, 2016, he testified Petitioner had degenerative spinal stenosis and there was no causal relationship between it and Petitioner's work accidents. On cross-examination, Dr. Li agreed that a right knee injury could cause one to have an altered gait and it was possible to develop back symptoms as a result thereof. (RX6; pp 32-33, 37-41)

Petitioner testified he still has right knee pain and instability. Petitioner stated he has zero trust in his right knee and said it has given way on him on a number of occasions. Since the knee surgery, Petitioner has regularly used either a crutch or cane to walk. Petitioner does want to proceed with having the total knee replacement surgery. Petitioner also continues to have low back pain and wants to receive treatment for that condition as well.

Michael Wroblewski testified at trial. Wroblewski stated he was Petitioner's supervisor at the time of both accidents. He testified Petitioner reported the accidents of October 17 and October 25, 2012, to him shortly after they occurred. In regard to the accident of October 17, 2012, Wroblewski's testimony was contrary to the "Witness Report" prepared by him on October 22, 2012.

CONCLUSIONS

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

Petitioner testified he was in the process of dismounting a work truck and, when he stepped down, he felt like something had ripped in his right knee. Petitioner reported the accident to Michael Wroblewski, his supervisor, immediately after it occurred. Petitioner informed Dr. Williams and Dr. Phillips he injured his right knee when he got out of a truck on October 17, 2012. When Petitioner was examined by Dr. Li, the report erroneously identified the date of accident as October 25, 2012 (the date of the second accident); however, the description of the accident was consistent with how the accident of October 17, 2012, occurred.

The Arbitrator concludes Petitioner sustained an accident that arose out of and in the course of his employment by Respondent on October 17, 2012.

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

Petitioner testified he reported the accident to Mike Wroblewski, his supervisor, on the date it occurred. While Wroblewski completed a "Witness Report" which stated Petitioner did not report an accident to him on October 17, 2012, his testimony at trial was that Petitioner did report an accident to him.

The Arbitrator concludes Petitioner gave notice in a timely manner to Respondent.

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

Even though Petitioner had a prior surgical procedure performed in 1993 on his right knee, he recovered and was able to work for Respondent in a full and unrestricted capacity until his right knee condition worsened after the accident of October 17, 2012, and meniscal surgery was required.

There was no question that the right knee surgery performed by Dr. Phillips was a result of the condition caused or aggravated by the accident of October 17, 2012. While Respondent's Section 12 examiner, Dr. Li, referenced the date of accident as being October 25, 2012, the description of its occurrence was consistent with the accident of October 17, 2012.

The opinion of Dr. Capecci that Petitioner's accident of October 17, 2012, aggravated the underlying arthritic condition was more persuasive than that of Respondent's Section 12 examiner, Dr. Li, that it only aggravated the meniscal condition.

Even though Petitioner had prior low back symptoms, he was able to work for Respondent in a full and unrestricted capacity until the accident of October 17, 2012. While Petitioner did not sustain any direct trauma to his low back on October 17, 2012, Petitioner's gait was altered as a result of his right knee injury which caused him to experience low back symptoms. Petitioner also informed Dr. Williams that he had complaints of low back pain which he attributed to physical therapy. The opinion of Dr. Mulconrey that Petitioner's altered gait aggravated or caused Petitioner's lumbar pain symptoms was more persuasive than that of Respondent's Section 12 examiner, Dr. Li, who opined that Petitioner did not sustain a spinal injury on the date of accident.

The Arbitrator concludes Petitioner's current conditions of ill-being in regard to both the right knee and low back are causally related to the accident of October 17, 2012.

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?

There was no dispute regarding the reasonableness or necessity of any of the medical services provided to Petitioner.

Based upon the Arbitrator's conclusion in issue (F), the Arbitrator concludes all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment for those medical services.

Issue (K): **Is Petitioner entitled to any prospective medical care?**

There was no dispute that Petitioner needs total knee replacement surgery and further treatment for his back condition.

Dr. Capecci and Respondent's Section 12 examiner, Dr. Li, agreed Petitioner needs total knee replacement surgery.

Respondent's Section 12 examiner, Dr. Li, deferred to Dr. Mulconrey's recommendations in regard to treatment for Petitioner's low back condition.

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including total knee replacement surgery and treatment for his low back, as recommended by Dr. Capecci and Dr. Mulconrey, respectively.

Issue (L): **What temporary benefits are in dispute?**

Petitioner claimed he was entitled to temporary total disability benefits of 203 3/7 weeks, commencing November 14, 2012, through January 30, 2014, and April 7, 2014, through December 13, 2016.

There was no dispute that Petitioner was temporarily totally disabled during the aforestated periods of time.

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 203 3/7 weeks, commencing November 14, 2012, through January 30, 2014, and April 7, 2014, through December 13, 2016.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eugene Allen,

Petitioner,

vs.

NO: 10 WC 34981

Strack & Van Til,

Respondent.

18IWCC0580

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice provided to all parties, the Commission after considering the issues of accident, timely notice, causal relationship, temporary total disability benefits, medical expenses both incurred and prospective, vocational rehabilitation, and permanent partial disability benefits, and being advised of the facts and the law modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes the parties do not dispute the occurrence of an accident on August 25, 2010 which resulted in injury to Petitioner's right shoulder. Respondent disputes a causal relationship for a lower back injury as a result of the same accident. Although the parties proceeded to hearing pursuant to Section 19(b) of the Act due to the issue of temporary total disability benefits and ancillary issues of prospective medical care and/or vocational rehabilitation/maintenance benefits, the parties also stipulated, in the alternative, the nature and extent of the injury was to be addressed. The Commission affirms the Arbitrator's finding of causal relationship for Petitioner's lower back injury as well as his right shoulder injury.

The Commission affirms the finding of a causal relationship between Petitioner's accident and his resulting conditions of ill-being to his right shoulder and lower back but modifies the date of maximum medical improvement (MMI) to October 31, 2012.

18IWCC0580

Maximum Medical Improvement

Petitioner underwent lumbar surgery on July 12, 2012. On July 18, 2012, Dr. Fink re-evaluated Petitioner who advised his back felt "great" but still voiced complaints regarding his right leg. Dr. Fink maintained Petitioner off-work through August 8, 2012 and recommended physical therapy. On August 8, 2012, Dr. Fink re-evaluated Petitioner and again maintained Petitioner's off-work status and continued to recommend physical therapy. On August 29, 2012, Dr. Fink re-evaluated Petitioner who reported seeking emergency treatment on August 24, 2012 due to severe leg pain. Dr. Fink maintained his recommendation for physical therapy as well as Petitioner's off-work status. On October 3, 2012, Dr. Fink re-evaluated Petitioner who voiced complaints of pain and blood in urine. Dr. Fink maintained Petitioner's off-work status. On October 31, 2012, Dr. Fink re-evaluated Petitioner who advised he "has been doing well regarding his lower back surgery." The physical examination showed a negative straight leg raise test. The only complaints voiced by Petitioner related to his right knee. PX5. Following October 31, 2012, Petitioner's treatment with Dr. Fink related to his right knee which the parties stipulated at trial was not caused by the August 25, 2012 accident. T. 15.

"The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized. [citations omitted]." *Mechanical Devices v. Industrial Commission (Johnson)*, 344 Ill. App. 3d 752, 760, 800 N.E.2d 819 (2003). Given the medical evidence, Petitioner's lower back condition stabilized as of October 31, 2012, therefore this date is the appropriate date for the establishment of MMI.

Temporary Total Disability/Medical Expenses

"The dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [citation omitted]. Once an injured employee's physical condition has stabilized, the employee is no longer eligible for TTD benefits because the disabling condition has become permanent. [citation omitted]." *Mechanical Devices* at 759. Based on the above finding of MMI, the Commission modifies the award of temporary total disability from August 31, 2010 through October 31, 2012, a period of 113-2/7 weeks. Respondent paid TTD benefits of $35,509.64 and is entitled to credit for same. The Commission further modifies the award of medical expenses to include charges for treatment rendered through the October 31, 2012 date of maximum medical improvement.

Vocational Rehabilitation

The Commission affirms the denial of vocational rehabilitation. As of October 31, 2012, Petitioner completed treatment for his lower back and embarked on a course of treatment for an unrelated knee condition. Petitioner offered no evidence regarding a job search, failed or otherwise, nor evidence from a vocational expert as to the necessity for vocational rehabilitation.

Further Petitioner provided a history of an ability to lift 70 pounds as of 2013 (PX23) which is well within his job requirements as a meat cutter. RX6.

Permanent Partial Disability

The Commission modifies the arbitration award of permanent partial disability benefits and awards 20% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. Petitioner suffered injury to both his right shoulder and lower back both resulting in the need for surgery. On February 24, 2011, Dr. Fink performed arthroscopic surgery to the Petitioner's right shoulder and on July 12, 2012 endoscopic surgery to treat protruding discs at the L3-L4 and L4-L5 levels. Both Dr. Fink and Dr. Levin found Petitioner able to return to work without restriction regarding his right shoulder, and Petitioner sought no additional treatment for his right shoulder condition after September of 2011. Regarding Petitioner's lower back condition, Petitioner reported feeling "great" as of July 18, 2012 with continued conservative treatment through October 31, 2012 at which time Petitioner's physical examination of his lower back was normal and was progressing well from the surgery. By 2013, Petitioner was able to lift 70 pounds. As such, the Commission finds an award of 20% loss of use of the person as a whole pursuant to Section 8(d)2 to be appropriate.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 30, 2017 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $400.00 per week for a period of 113-2/7 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable, necessary and related medical expenses for treatment of Petitioner's right shoulder and low back through October 31, 2012 pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $360.00 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 20%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $35,509.64 in TTD benefits.

18IWCC0580

IT IS FURTHERED ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act in the amount of $96,229.66; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order. This amount shall not be added to the bond calculation.

IT IS FURTHER ORDERED BY THE COMMISSION 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 $45,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 25 2018
LEC/maw
o07/25/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

ALLEN, EUGENE
Employee/Petitioner

Case# **10WC034981**

STRACK & VAN TIL
Employer/Respondent

18IWCC0580

On 6/30/2017, 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 1.11% 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:

2573 MARTAY LAW OFFICE
DAVID M MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

3998 ROSARIO CIBELLA LTD
JANE M RYAN
116 N CHICAGO ST SUITE 600
JOLIET, IL 60432

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)

Eugene Allen
Employee/Petitioner

v.

Strack & Van Til
Employer/Respondent

Case # 10 WC 34981

Consolidated cases:
18IWCC0580

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 **Arbitrator STEFFEN FOR Gale**, Arbitrator of the Commission, 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, **August 25, 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 accidentwas given to Respondent.

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

In the year preceding the injury, Petitioner earned **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **45** years of age,**married** with **3** dependent children.

Respondenthas not paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$35,509.64** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$35,509.64**.

Respondent is entitled to a credit of **$96,229.66** under Section 8(j) of the Act.

Petitioner is not entitled to vocational assistance.

Petitioner suffered a loss of 12.5% of man as a whole for his right shoulder injury and 12% of man as a whole for his lower back injury.

ORDER

C.
The Arbitrator finds Petitioner has proven by a preponderance of the evidence that an accident occurred that arose out of and in the course of his employment by Respondent. Said accident caused an injury to his right shoulder and to his lower back.

E.
The Arbitrator finds Petitioner has proven by a preponderance of the evidence that timely notice of the accident was given to Respondent.

F.
The Arbitrator finds that the Petitioner 's current condition of ill being is not causally connected to his work accident of August 25, 2010 while employed by Respondent.

J.
Respondent has requested medical bills of $80,160.00 owed to Dr. Robert Fink; $53,918.44 owed to rogers Park One Day Surgery Center; $8,895 owed to Chatham Advance Pain Relief; $22,553.08 owed to Accelerated Rehabilitation Centers; $3,050.00 owed to Advantage MRI; $1,240.00 owed to Neuromonitoring Services of America; $9,043.02 owed to RX Development; $10,370.50 owed to Industrial Pharmacy Management; $17,900 owed to Dr. John Mazzarella; $2,804.00 owed to Advanced Lab Services and $4,953.94 owed to Prescription Partners. The Arbitrator awards bill related to the right shoulder and the low back till the MMI date of July 18, 2012. The Arbitrator specifically does not award any medical bills for the knee treatment and gall bladder issues. The bills (specially for physical therapy and pharmaceuticals do not clearly indicate that they are right shoulder or lower back (work injuries)

related. The bill that are reasonable and related shall be paid by the Respondent per the statutory medical fee schedule.

K.
The Arbitrator finds that the Petitioner has failed to meet his burden to show that he is entitled to prospective care.

L.
The Arbitrator finds Petitioner is entitled TTD benefits at the rate of $400 for the period of 8/31/10 through July 18, 2012. (to 97 and 5/7th weeks of temporary disability benefits at the rate of $400.00 totaling $39,084.00.) Respondent is due a credit of $35,509.64.

Permanent Partial Disability
The Arbitrator awards 12.5% for man as a whole ($360 x 62.5 weeks = $22,500.00) for Petitioner's operated right shoulder. The Arbitrator awards 12% of a man ($360 X 60 weeks =$ 21,600.00) for Petitioner's operated lower back.

O.
The Arbitrator declines to awards Vocational Rehabilitation.

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/Date KSSteffen

ICArbDec19(b)

JUN 30 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EUGENE ALLEN	)	
	)	
Petitioner,	)	
vs.	)	
	)	No. 10 WC 34981
STARCK & VAN TIL	)	
	)	
Respondent.	)	

Procedural History

This 19b/8a petition was tried before Arbitrator Gary Gale on January 19, 2016. The Parties stipulated and agreed that the Arbitrator should also make a finding as to permanency, if appropriate. The Parties have have also agreed to have the decision rendered by a different Arbitrator. Arbitrator Ketki Steffen has examined the transcript and submitted records and evidence in rendering her opinion.

Ruling Amelia Madden Letter:

Petitioner's Exhibit 8 contains a letter authored by Amelia Madden. Said letter was objected to by Respondent as hearsay. Arbitrator Gale reserved ruling on this issue and the record indicated that he was to give such a ruling after the hearing during his decision. Arbitrator Steffen hereby rules the letter as inadmissible hearsay as it is not a business or medical record kept in the regular court of business.

Factual History

Petitioner, Eugene Allen, was 45 years old at the time of his work accident of August 25, 2010. He had been working as meat cutter for the Respondent, Starck & Van Til, for over seven years. He had three minor children under the age of 18 at the time of his accident. Petitioner job duties as a meal cutter included getting meat out of the cooler and using a saw to cut it. On August 25, 2010, he went to a cooler to get a box of ox tails. The cooler was high so he used a ladder. On the way down, he slipped and fell. His fall was broken by a co-worker. Petitioner testified that he felt immediate pain in his right shoulder, neck and low back. Petitioner was taken by his manager to the emergency room at Loyola (Px 2). He reported

right shoulder pain status post lifting heavy boxes while at work today. Petitioner reported "lifting boxes while on ladder, pain started while handing off box." He complained of pain to entire RUE, positive range of motion but painful, positive CMS, no other injuries-complaints. Petitioner was given an arm sling and told to return to work the following day, August 26, 2010, with restrictions of no lifting with the right arm for 1 week. X-rays were taken which revealed no fracture. Petitioner was given a sling, NSAIDs, and Flexeril. He was to follow up with occupational health. The medical record contains no mention of petitioner's lumbar spine. (Px. 2, Rx. 2.)

On August 26, 2010 Petitioner presented to a chiropractor, Dr. Daniel Cammarano for an evaluation (Px 21 at 7). His subjective complains were pain in the bilateral region of his neck, radiating into the right arm. He also complained of frequent pain in the bilateral mid back and right shoulder joint pain (Px 21 at 8). Dr. Cammarano's initial diagnosis was a cervical/thoracic strain/sprain, right shoulder strain/sprain and myalgia (Px 21 at 9-10). There was a range of motion testing done at the office. He recommended Petitioner undergo a course of chiropractic treatment at his office (Px 21 at 11).

Petitioner returned to Dr. Cammarano and complained of worsening pain to his neck and right arm. He underwent therapy to the cervical and thoracic and shoulder region.

Dr. Cammarano prepared a Family and Medical Leave Act (hereinafter "FMLA) form for Petitioner on September 16, 2010 (Px 21 at 18). On the FMLA form, Dr. Cammarano noted that he was treating Petitioner for an injury to his "right shoulder and lower back pulling meat off the shelf at work. Patient receiving daily therapy for cervical, lumbar and right shoulder pain" (id.). This report was completed approximately 3 weeks after Petitioner's work-injury.

On October 8, 2010 Petitioner underwent an MRI as right shoulder not showing much improvement. The MRI of his right shoulder which was done on October 8, 2010 at Advantage MRI (Px 13). Following the MRI, Dr. Cammarano sent Petitioner to see Dr. Robert Fink for an orthopedic examination (Px 21 at 16-17). He continued therapy with Dr. Cammarano through January 18, 2011.

On April 28, 2011 Dr. Cammarano authored a 'Work Comp Interim Report' (Px.7). He testified in his deposition (Px.21 at 41) that he did not know whether he examined Petitioner on this date or not. Petitioner's Exhibit 9 does not contain a bill for this date of service. The "report" indicated that Petitioner complained of pain in the right shoulder joint and lumbar pain. This is the first time that the lumbar spine is mentioned in Dr. Cammarano's medical records.

The diagnosis was chronic lumbar sprain/strain, post-surgical shoulder-rotator cuff and myalgia. There was lumbosacral and right shoulder range of motion testing performed.

On October 25, 2010 Petitioner presented to Dr. Fink for an initial examination (Px 3 at 8). He diagnosed Petitioner with right shoulder impingement syndrome caused by the August 25, 2010 work-injury (Px 3 at 11-12). Dr. Fink performed an injection in to Petitioner's right shoulder and authorized him off work (Px 3 at 12-14). A second injection to the right shoulder was done on November 8, 2010 (Px 3 at 14). Dr. Fink also noted that Petitioner was still seeing Dr. Cammarano for his back condition (id.). A third injection for Petitioner's right shoulder was done on November 22, 2010 (Px 3 at 15-16).

Following the injections, Petitioner saw Dr. Fink again on December 13, 2010 and Dr. Fink recommended Petitioner undergo surgery for the right shoulder (Px 3 at 16). Petitioner was asked to keep off work.

On January 24, 2011, Petitioner followed up with Dr. Fink. The doctor stated that the MRI confirmed that the petitioner had supraspinatus tendonitis caused from impingement syndrome. The doctor now recommended the outpatient surgery to relieve his pain. This surgery would be an acromioplasty of the right shoulder. He was to be off work through March 2, 2011.

On February 24, 2011, upon approval from workers' compensation, Petitioner underwent surgery for his right shoulder (Px 3 at 17). The procedure included an arthroscopic debridement of a labrum tear, partial synovectomy and open Neer Acromioplasty (Px 4).

Following the surgery, Dr. Fink recommended physical therapy. (Px 3 at 20-21) Petitioner presented to Accelerated Physical Therapy on May 12, 2011 for treatment to his right shoulder. Petitioner relayed a history of the work injury. Treatment was recommended for three to four weeks. Petitioner had therapy on May 14, 2011. Petitioner reported his back was bothering him. He had therapy on May 17, 18, and 20 at which time he reported his back had been sore since the date of injury. Therapy continued onto May 26, 27, and 31. (Pet.Ex.10)

Petitioner also saw Dr. Fink post-operatively for routine follow-up examinations (Px 3 at 20-21).

At the June 1, 2011 exam, Dr. Fink recommended Petitioner undergo an MRI of his lumbar spine due to some lumbar issues (Px 3 at 23). The MRI was done on June 4, 2011 and showed protruding lumbar discs at L3-4 and L4-5 (Px 3 at 24). When Petitioner followed up

with Dr. Fink on June 15, 2011 he recommended Petitioner continue physical therapy and possibly undergo some lumbar epidural steroid injections (Px 3 at 25-26). Dr. Fink testified that there was a causal connection between the low back issues and Petitioner's work-injury (Px 3 at 27).

Meantime Petitioner continued his physical therapy for his right shoulder through the end of June, 2011.

On June 29, 2011 Petitioner presented to Dr. Jay Levin for a Section 12 examination at the request of the Respondent (Rx 5 at 7). Petitioner complained of low back and right shoulder issues caused by his work-injury of August 25, 2010 (id.). Dr. Levin opined Petitioner was at maximum medical improvement (hereinafter "MMI") for the right shoulder and could return to work with no lifting over 15 lbs. (Rx 5 at 16). Dr. Levin did not initially offer any an opinions regarding the lumbar spine. (Rx 5 at 15-16). Once he reviewed some additional records, he opined that the lumbar spine issues were not related to Petitioner's August 25, 2010 work-injury (Rx 5 at 18).

Petitioner underwent lumbar epidural steroid injections with Dr. Fink at L3-4 and L4-5 on September 8, 2011 (Px 3 at 30). He was directed to remain off work till September 28, 2011. Dr. Fink recommended Petitioner undergo a second set of injections during a follow-up-exam on September 28, 2011 (Px 3 at 31). Following some more follow-up- exams, another set of injections were performed on December 8, 2011 (Px 3 at 32).

In the meantime, on September 14, 2011, Petitioner had an FCE performed at Accelerated Rehabilitation Center for his right shoulder. This FCE came back invalid and unreliable due to submaximal performance demonstrated by the petitioner. Furthermore, the petitioner failed 8 out of 15 objective validity criteria and demonstrated inconsistent reliability (Pet.Ex.10, Resp.Ex.4). After the FCE, on September 20, 2011, Petitioner was reevaluated by Dr. Fink. The doctor only addressed that the FCE was invalid and did not elaborate. Petitioner was discharged from therapy on September 22, 2011 stating he was waiting for instructions from his attorney (Pet.Ex.10).

This right shoulder FCE was sent to Dr. Jay Levin for his review. In a letter dated October 18, 2011, Dr. Levin opined that Petitioner should be expected to be able to return to work with respect to his right shoulder in a full duty unrestricted capacity. The doctor reiterated that Petitioner was at MMI for his right shoulder.

Petitioner continued to follow-up- with Dr. Fink almost monthly throughout the early part of 2012 until surgery was recommended for Petitioner's back. Dr. Fink performed an endoscopic partial discectomy L4-5 and L3-4, foraminectomy L4-5 and L3-4 and a radiofrequency annuloplasty L4-5 and L3-4 on July 12, 2012 (Px 5).

Petitioner continued to treat with Dr. Fink throughout the rest of 2012 and in to 2013 (Px 5). As of March 11, 2013, Dr. Fink continued to authorize Petitioner off work for his back and right shoulder issues (Px 3 at 40).

Petitioner presented to Dr. Jay Levin for a second Section 12 examination at the request of Respondent on November 6, 2013 (Rx 5 at 28). He continued to opine that Petitioner's back injury was not related to the work-injury from August 25, 2010 (Rx 5 at 34-35).

Dr. Fink continued to see Petitioner throughout 2013 and in to 2014 on about a monthly basis and continued to authorize Petitioner off work (Px 3 at 41-44). As of September 15, 2014, Dr. Fink believed Petitioner might benefit from a functional capacity evaluation (hereinafter "FCE") to see what his work capabilities were (Px 3 at 45-46). He also continued to authorize Petitioner off work (Px 3 at 48-49).

Dr. Fink continued to authorize off work through early 2015 and continued to recommend Petitioner undergo a FCE (Px 4 & 22). An FCE was done on March 3, 2015 at Work Well Systems, Inc. (Px 23). The FCE shows Petitioner gave maximum effort on all test items and placed him at a light level of work which does not meet his job demands (id.). It was recommended that he might benefit from some more low back treatment and possible work hardening (id.). Dr. Fink continued to authorize Petitioner off work through 2015 and has recommended Petitioner undergo a discogram (Px 22).

Petitioner testified at trial that he still experiences constant lower back pain and that he wishes to continue receiving medical care to help cure that pain. He also continues to have some right shoulder pain although that pain is not as bad as his back. His shoulder hurts him most when he has to carry groceries. In order to treat his pain, he takes several medications prescribed by Dr. Fink. It should also be noted that Petitioner applied for and was approved for Social Security Disability Income benefits.

Dr. Jay Levine (RX5)

Dr. Jay Levin was deposed on April 8, 2014. Dr. Levin testified that he was an orthopedic and spinal surgeon who was board certified. He had a specialty of orthopedic

surgery within his board certification. He attended Northwestern University followed by Rush Medical College. He did his internship which was a residency in orthopedic surgery at Rush Presbyterian St. Luke's Medical Center now call Rush University. (Resp.Ex.5)

Dr. Levin first saw the Petitioner on June 29, 2011. At that time, the Petitioner reported that on August 25, 2010, he was on the top of a three-foot step ladder, he had his arms extended out in front of him grabbing a box of oxtails which he stated weighed approximately 15 pounds. As he was pulling the box towards him, he was turning his full body to the left to give the box to his coworker and he felt pain in the right shoulder. He had a loss of feeling in the entire right side. He started to fall but a coworker caught him. (Resp.Ex.5 at 8) Dr. Levin performed a physical examination. He also reviewed radiographs of the lumbar spine, pelvis x-rays and x-rays of the right shoulder. He also reviewed an MRI study of the lumbar spine from June 4, 2011. Dr. Levin diagnosed the Petitioner as being status post right shoulder arthroscopic labral resection with partial synovectomy and open Neer Acromioplasty. Dr. Levin recommended no further treatment for Petitioner's shoulder. Dr. Levin requested to review additional medical records before opining on the Petitioner's lumbar spine. Dr. Levin felt that Petitioner had reached maximum medical improvement for the right shoulder as of June 29, 2011. (Id. at 16)

Dr. Levin was then later provided the additional medical records that he requested and he authored a second report dated July 15, 2011. The doctor stated that it did not appear that the Petitioner had an injury to his lumbar spine from the August 25, 2010 occurrence. (Id. at 18) The basis of his opinion included: (1) the Loyola University Healthcare medical record containing no complaints of the lumbar spine and a physical examination done at that time was consistent with the absence of a spinal cord injury and (2) no complaints or treatment to the Petitioner's lumbar spine from October 25, 2010 (when Petitioner first saw Dr. Fink) until May 2011 which was almost nine months after the original injury. (Id. at 19–21) Dr. Levin further opined that a maximum medical improvement statement could not be made with respect to Petitioner's lumbar spine since it was in no way related to the August 25, 2010 injury.

Dr. Levin authored a third report dated October 18, 2011. At that time, he was provided a functional capacity examination done on Petitioner's right shoulder. Dr. Levin stated that that was not a valid study. He reiterated that the Petitioner failed 8 out of 15 objective validity criteria and demonstrated inconsistent reliability. The doctor concluded that this meant

Petitioner was functioning or capable of functioning at a higher category of work than he demonstrated in the recorded measurements in that study. Dr. Levin also reviewed a job description for a butcher. Dr. Levin continued to opine the Petitioner had reached a maximum medical improvement as of that time for his right shoulder. The FCE supported the doctor's MMI finding on the shoulder from July 2011 and supported the doctor's opinion that Petitioner did not need any work restrictions for his right shoulder.

Dr. Levin authored a fourth report dated November 6, 2013. He reexamined the Petitioner and at that time he had reviewed additional medical records. Petitioner presented to the doctor with a cane in his right hand. He reported that prior to his lumbar spine surgery, he had shooting pain from his neck down to his right toes. Since the surgery, he had pain in the low back down his right leg to his toes. He had not had a new MRI study since his surgery. He used a TENS unit at home for one hour a day. It was also noted that he had had right knee surgery on April 13 done at University of Illinois through Public Aid. The doctor viewed additional x-rays and requested that an MRI study of the lumbar spine be performed.

The requested MRI study was performed at which time he authored a fifth and final report dated November 26, 2013. The doctor reviewed the updated MRI and he also reviewed additional medical records including the operative report from the lumbar spine surgery. The doctor testified: "[t]here is nothing I found which would be inconsistent with the initial opinions I expressed regarding the lumbar spine and the basis of those opinions as memorialized in my reports and I stood by those opinions after a thorough evaluation was done." (Id. at 35) Dr. Levin also testified that regardless of causation, he would not have recommended the lumbar spine surgery for this Petitioner (Id. at 35–6) The doctor testified: "The records do not support that this man had any injury regarding his lumbar spine from an occurrence of August 25, 2010…I do not believe that the surgical intervention that he ultimately underwent on the lumbar spine is at all related to August 25, 2010 accident." (Id. at 36) Dr. Levin stated that the Petitioner needed no lumbar spine restrictions as it related to the August 25, 2010 incident (Id. at 36-7).

On cross-examination, Petitioner's counsel provided Dr. Levin with an employee's report of claim which he claimed contained a statement of Petitioner complaining of low back pain in September 2010. The doctor testified that this could change his opinion if there were other medical records which included clinical complaints by healthcare providers, physical examination findings which include local edema things like that then his opinion could be

changed (Id. at 53). The doctor would make no comment on Dr. Camarano's apparent medical record inaccuracies as the Amelia Madden letter was not dated and he felt that inaccurate medical records were a "deviation from the standard of care." He stated that he would be happy to review Dr. Camarano's deposition testimony and comment on that issue. Dr. Levin also noted that Amelia Madden's letter was not authored by a healthcare provider but a third party. In fact, that Ms. Madden was not even a nurse.

Finally, Dr. Levin testified on cross-examination that there were no other histories in the medical records as to how else petitioner injured his low back. (Id. at 59)

Dr. Daniel Cammarano (PX21)

Dr. Cammarano was deposed on April 25, 2014. The doctor testified that he sees approximately 100 patients per month. Dr. Cammarano testified that he initially saw the Petitioner on August 26, 2010 and that he had no knowledge of the work injury other than it occurred at his work. Dr. Cammarano also knew that Petitioner was a meat cutter. On August 26, 2010, the Petitioner complained of pain in his neck, mid-back, and right shoulder. He performed range of motion examination of the cervical spine and right shoulder. Dr. Cammarano diagnosed the Petitioner with a cervical and thoracic sprain/strain, a right shoulder strain/sprain and myalgia. (Pet.Ex.21)

Dr. Cammarano testified that he later saw the Petitioner on April 28, 2011. He testified that it was not until his April 28, 2011 record that noted pain in Petitioner's lower back. Dr. Cammarano later stated that the reason his medical records from September 2010 through the end of April 2011 were devoid of any lumbar spine complaints, treatment, or billing codes was because he utilized a computer program that allowed him to input data into a software system to generate a report. Cammarano stated he was responsible for inputting all the entries into the system he used, called Auto-doc, however, on occasion he would ask his staff to assist (Pet.Ex.21 at 20-1). Dr. Cammarano reviewed a letter authored by an Amelia Madden. (The letter was objected to by Respondent and Arbitrator Steffen has sustained Respondent's objection). The doctor testified that Amelia Madden was no longer employed by him but had previously worked for him in a billing capacity. The doctor testified he did not sign this letter, he did not believe he "informed her to write this letter" (Id. at 23-4)

On cross-examination, Dr. Cammarano testified that in 2010 he saw approximately 1,200 patients a year. The same amount would be accurate for the year 2011. The doctor explained that the computer program he referenced was a touch screen so therefore the

information had to be input by him when carrying around a tablet or inputting when sitting at a desk and putting the information into a desktop computer. (Id. at 31-2) He testified that that was something he would personally do for every medical record. (Id. at 32) However, the doctor then stated that sometimes his assistant would create the medical records. In that case, he would tell them "exactly what I want input into the system if I had my hands on the patient or something and they will do so." (Id.)

Dr. Cammarano admitted on cross examination that in every single medical record from August 2010 until January 20, 2011 that the word lumbar spine appeared nowhere in his medical records. (Id. at 34). He then did not treat the Petitioner for three months. In every one of those records, there were three separate entries that mention nothing about a lumbar spine: (1) Petitioner's subjective complaints, (2) the doctor's diagnosis and (3) the areas that manipulations or treatments were administered to. (Id. at 34). The doctor also stated that when he sees a patient, he reviews the medical records from a prior visit. At no point when reviewing the prior medical records from Petitioner did he see that there was an alleged inaccurate description of what body part was complained of, diagnosed, or treated. (Id. at 35).

Dr. Cammarano testified that when Petitioner's right shoulder condition did not improve with his chiropractic treatments, he referred him for an MRI. (Id. at 36). However, the doctor never recommended an MRI of Petitioner's lumbar spine nor did he recommend x-rays of his lumbar spine (Id.). Dr. Cammarano further testified that he was not aware that the Petitioner failed to mention his lumbar spine in the emergency room records from August 25, 2010 and that that would have been somewhat relevant to him in formulating his causal connection opinion. (Id. at 36-7). Furthermore, Dr. Cammarano testified that he never reviewed Dr. Fink's medical records. He was not aware that Dr. Fink's medical records from October 2010 to June 2011 make no mention of the lumbar spine or lumbar spine complaints. (Id. at 37). He also said that that information could be relevant in his formulation of a causal connection opinion.

In addition, Dr. Cammarano testified on cross-examination that he had a conversation with the Petitioner regarding his medical records (Id. at 38). Dr. Cammarano testified that Petitioner came to his office in the summer of 2013 to discuss what was going on with his condition. However, there was no medical record to document that meeting. The doctor stated that he remembered this conversation because he and the Petitioner would joke when he placed electrodes and had treatment to the buttock area (Id. at 39). However, the doctor

testified that this placement of electrodes on the Petitioner's buttocks was not reflected anywhere in his medical records. (Id.). The doctor also testified that there were several medical bills submitted into evidence that did not correspond to a medical record including October 8, 2010, October 27, 2010 and January 20, 2011. The doctor could not say why there was no report or medical record corresponding to those bills. (Id. at 39-41). What's more, Dr. Cammarano testified on cross-examination that he did not have a bill for the April 28, 2011 visit which he summarized in a "work comp interim report". He did not recall whether he examined the Petitioner at that time or if he just authored a letter summarizing Petitioner's condition. Petitioner did not return to Dr. Cammarano after April 2011.

With respect to the alleged error in Petitioner's medical records the doctor was not sure when he first became aware of these alleged problems. The doctor also could not say how many of his other of his patients had errors in their medical records. (Id. at 42). In fact, the doctor testified that this would be an isolated case. The doctor stated that "it is not proper to change it or to try to remedy it, so I have left it the way it was" in reference to how he tried to remedy the alleged error in the Petitioner's medical records. Dr. Cammarano testified that he did not inform the Petitioner or any other patients whose medical records were allegedly incorrect informing them that their medical records were not properly documented. (Id. at 43). In addition, Dr. Cammarano testified that the CPT code for lumbar spine is 847.2. However, he agreed that there were no CPT codes for the lumbar spine in his medical bills. (Id. at 44).

Dr. Robert Fink (PX3,PX4, PX5, PX22)

Dr. Robert Fink was deposed on October 22, 2014. He testified that he first saw the Petitioner on October 25, 2010. At that time, Petitioner complained of pain in the right shoulder which he stated started when he was involved in a work injury two months prior. He understood that the Petitioner was a meat cutter that he was getting an ox tail and felt a sharp pain and lost use of his right shoulder. Another worker caught him from falling to the ground. Petitioner rated his pain as an eight out of ten. The doctor diagnosed Petitioner's right shoulder condition as being impingement syndrome of the right shoulder with rotator cuff injury with a tendinitis. He believed that this is causally related to the work injury.

He saw the Petitioner again on November 8, 2010. He stated that Petitioner had benefited from the shot so a second injection was done at that time. A third injection was administered on November 22, 2010. In December 2010 and January 2010 surgery was

discussed. The surgery occurred on February 24, 2011. When in surgery it was determined that the rotator cuff had some inflammation but there was no major tear. Petitioner had a partial tear of the labrum and synovitis (Pet.Ex.3 at 18-19). It was further determined that there was no impingement on the rotator cuff.

Dr. Fink saw Petitioner for a follow up. He had post-operative physical therapy. As of June 2011, Petitioner was doing much better, his range of motion was improving and he could do his active assisted exercises. He could lift 10 pounds. It was at that visit, on June 11, 2011, that Petitioner stated that his low back "went out". This was the first-time Petitioner's low back pain was complained of to Dr. Fink. As soon as this complaint was made, the doctor ordered an MRI of the lumbar spine (Pet.Ex.3 at 23). Petitioner had had the MRI study. The doctor reviewed the MRI study and determined that he had a protruding lumbar disc at L3-4 and a protruding lumbar disc at L4-5. A lumbar epidural steroid injection was discussed. He was to continue physical therapy.

In July, 2011, the doctor testified that Petitioner's shoulder was progressing well. In August 2011, he was prescribed work conditioning for his shoulder. A lumbar epidural steroid injection was performed in September 2011. Eventually, Dr. Fink performed surgery on the Petitioner's lumbar spine on July 12, 2012. The doctor stated that in October 2012, the Petitioner told him that he had fallen on the day of surgery and hurt his right knee. That was the first time that the right knee had been mentioned to Dr. Fink (Pet.Ex.3 at 38). An MRI of the right knee was ordered by Dr. Fink. In December 2012, Petitioner reported that his back felt better it was his right knee that was bothering him. Furthermore, Dr. Fink testified that Petitioner's back had been aggravated when he injured his knee. He explained: "You don't put your weight equally on both legs, so the back had been aggravated a little bit with this knee problem and the knee surgery so he still had to use his back brace" (Id. at 41). As of September 2013, Petitioner was then using a cane which Dr. Fink stated was for "a combination of the back and the right knee". He had negative straight leg raising right and left leg. He had weak quadriceps strength on the right and that can be related to having the knee injury and having surgery and limping. As of January 20, 2014, the doctor stated the Petitioner's low back pain was "significantly improved" (Id. at 43). At that time, Petitioner was doing a home exercise program, he was no longer in therapy and was on a medication called Neurontin. The doctor stated that Petitioner was on Neurontin because his back was "aggravated a little bit with his knee problem" (Id. at 43). The doctor testified that if Petitioner

was on a low dose of Neurontin he would be able to work as a meat cutter while taking it (Id. at 44).

On cross examination, Dr. Fink testified that he never reviewed any of Dr. Camarano's medical records (Pet.Ex.3 at 53). Therefore, he did not know what area of the back the Petitioner was treating for although he was "pretty sure" he was doing his neck and his lower back. The doctor stated that he would have to review Dr. Camarano's records before saying for sure what part of the back was being treated (Id. at 55). Dr. Fink testified that when he first saw the Petitioner intake paperwork was filled out and the only area Petitioner circled as being an area of pain was his right shoulder (Id. at 55-6).

Dr. Fink reiterated on cross examination that he did not prescribe any treatment on the low back until June 2011 which at that time was 9 months after the alleged work injury (Id. at 56-7) and as soon as Petitioner mentioned his low back to Dr. Fink, he ordered an MRI. Furthermore, Dr. Fink testified that he did not review Accelerated Rehab's medical records to see if there was any documentation of an injury occurring in physical therapy (Id. at 57-8).

Dr. Fink mentioned nothing about Petitioner's failed FCE for his right shoulder on direct examination. On cross examination, the doctor reviewed the FCE and agreed that it was an invalid study and that it was not an accurate assessment of what the Petitioner could do for his right shoulder. Therefore, he did not prescribe any permanent restrictions with respect to Petitioner's right shoulder (Id. at 59).

With respect to the effect of Petitioner's unrelated right knee condition on his lumbar spine, the doctor stated that the right knee threw off the back because he was not walking equally on his legs (Pet.Ex.3. at 60). At the time of his deposition, Dr. Fink testified that he still thought Petitioner could "get a little bit better" on his back as he recovered from his knee surgery and continued to take the Neurontin (Id. at 61). Dr. Fink agreed that the right knee injury was not related to the work injury (Id. at 62). Dr. Fink did not review a job description for Petitioner's position as a meat cutter nor did he review any of Dr. Levin's Independent Medical Examination reports (Id. at 62-3).

Petitioner was seen by Dr. Fink on November 12, 2014 and was kept off work through December 17, 2014. An MRI was prescribed of the lumbar spine.

Petitioner was seen by Dr. Fink on December 3 and December 17, 2014, January 26, 2015 and February 4, 2015 and was kept off work.

Analysis/Findings

Regarding issue (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

Respondent agrees an accident occurred to Petitioner's right shoulder on August 25, 2010, however, Respondent disputes an accident occurred to Petitioner's lumbar spine on August 25, 2010. Respondent relies on Respondent's Exhibit 1 – First Report of Injury or Illness – and Respondent's Exhibit 2 – the Illinois Form 45 that list only the "right shoulder and upper chest." Neither document mentions the low back pain or injury.

There is no mention of Petitioner's low back in Rx1, merely a report of injury to the right shoulder and upper chest on August 25, 2010. However, RX1 is not signed or dated by any party. PX2, dated August 29, 2010, lists states "multiple body parts" under the section asking what body parts were affected. In the Arbitrator's opinion, Px2 does not discount the back injury per se.

In contrast PX1, the Employee's Report of Claim, documents the complaint of back injury. This report is dated August 31, 2010 and is well within the 45-day notice requirement. This report states on page one under the section asking to describe the injury or illness, "neck pain, shoulder pain and lower back pain". On page 2 the report asks to explain your present condition in detail and the report states, "pain constantly in my neck, shoulder and lower back…". This report is signed and dated by Petitioner on September 7, 2010.

Additionally, an FMLA report authored and signed by Dr. Cammarano on September 16, 2010 (Px 21, Dep. Ex #1) also documents Petitioner's complaint of back injury. This report states on page 2 that "Patient injured right shoulder and lower back pulling meat off the shelf at work. Patient receiving daily therapy for cervical, lumbar and right shoulder pain" (Px 21 at 18).

Lastly, Petitioner's testimony supports that he injured his right shoulder as well as in lower back on August 25, 2010. Respondents' arguments that Dr. Cammarano's records do not document a back injury is not wholly without merit. Dr. Cammarano was Petitioners first treater. He failed to consistently document Petitioner's back injury. After many months of silence on the issue of back injury, Dr. Cammarano documents the back injury in April, 2011. The deficiency in his record-keeping is troubling because although a physician is presumed to be free of bias, as a treater, Dr. Cammarano has some interest in his patient's wellbeing. However, this is a far cry from a claim that Dr. Cammarano's testimony regarding the back injury and his explanation of bad record keeping is fabricated. In his deposition, he gave a

detailed description of the mistake that was made in regards to the medical records (Px 21 at 20-21). He detailed a glitch in his computer software system which resulted in the lack of records related to treating Petitioner's low back.

The Arbitrator finds Dr. Cammarano's detailed explanation to be credible. The primary reason for this is that the Petitioner's testimony is credible and is supported by the Employee Report of Claim form (PX1). This report generated on August 31, 2010 (a few days after the injury) clearly shows that Petitioner claimed that he had lower back pain. PX7, Dr. Cammarano's Health insurance claim forms also contain the Injury Initial Examination/Evaluation Report. This is dated 8/26/10. Under subjective complaints it states "Mr. Allen stated that he is experiencing:2: Frequent (51 to 75% of awake time) pain in the bilateral mid back. He rated the pain 8/10.region of the neck ". For the Arbitrator, this along with the FMLA document is powerful corroboration to Petitioner's testimony that he injured his neck/shoulder as well as his lower back. Respondent's arguments that there is no documentation in the medical records of a lumbar spine complaint or treatment until April 28, 2011, which is over eight months after the injury, is not persuasive.

Therefore, the Arbitrator finds Petitioner has proven by a preponderance of the evidence that he suffered a work accident to his right shoulder and lower back that arose out of and in the course of his employment.

Regarding issue (E), was timely notice of the accident given to Respondent, the Arbitrator finds the following:

Petitioner's Exhibit #1 in conjunction with Respondent's Exhibits #1 and #2 clearly show timely notice of Petitioner's accident was provided to Respondent. Respondent agrees that notice was provides regarding the right shoulder injury. Respondent denies any notice of the low back injury.

The Arbitrator finds Petitioner has given credible testimony regarding his accident, the nature of his injury and that he provided notice to the Respondent. The PX1 document which is the Employee's Report of Claim from memorializes that Petitioner also complained of low back pain. This report is dated August 31, 2010 and is well within the 45-day notice requirement. This report states on page one under the section asking to describe the injury or illness, "neck pain, shoulder pain and lower back pain". On page 2 the report asks to explain

your present condition in detail and the report states, "pain constantly in my neck, shoulder and lower back...". This report is signed and dated by Petitioner on September 7, 2010.

The Respondent is correct that when Petitioner first seeks medical treatment at the Loyola ER on the date of accident, he only complained of right shoulder pain. However, this issue is not detrimental to the Petitioner's case considering the written statements from his Employee Report of Injury and his FMLA forms. The Medical reports are prepared by the hospital and although the lack of mention of back pain is probative, it is not sufficient to impeach the Petitioner's testimony and the evidence from other documentations..

The Arbitrator recognizes the Loyola ER reports, Respondents First Report of Injury or Illness (RX1) as well as Dr. Cammarano's reports are being used to impeach the testimony of the Petitioner. However, the Arbitrator recognizes the inherent risks and evidentiary issues with impeaching a witness using documents and forms prepared by someone else, especially when the Petitioner has not had the opportunity to examine, sign or adopt the same. This does not imply that such impeachment cannot be successfully perfected with testimony form the preparer of the forms. However, the Arbitrator weighs and assesses such impeached in the totality of all the other documentary evidence that supports Petitioner's contention. The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that timely notice of the accident was given to Respondent.

Regarding issue (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

Petitioner credibly testified he injured his right shoulder and low back on August 25, 2010 when he went in to the cooler to grab some ox tails using a ladder. As he was coming down ladder, he slipped and was caught by a co-worker. He felt immediate pain in his right shoulder, neck and low back. Petitioner was taken by his manager to the emergency room at Loyola (Px 2).

His injuries have led to medical treatment for both his right shoulder and low back. Petitioner underwent surgery for his right shoulder with Dr. Fink on February 24, 2011 (Px 3 at 17). The procedure included an arthroscopic debridement of a labrum tear, partial synovectomy and open Neer acromioplasty (Px 4). Petitioner underwent surgery for his low back on July 12, 2012 when Dr. Fink performed an endoscopic partial discectomy L4-5 and L3-4, Foraminectomy L4-5 and L3-4 and a Radiofrequency Annuloplasty L4-5 and L3-4 (Px 5).

The Respondent does not contest the right shoulder injury and has approved and paid for the medical treatment relating to the same. As to the lower back the Respondent denies the causal connection largely based on the blatant and repeated gaps in reporting the back injury and in the Petitioner's passive failure in not seeking active treatment for the same for 8-9 months. Although the Arbitrator greatly agrees with the Respondent's arguments regarding Dr. Cammarano's medical records and Petitioner's failure to mention the back injury to Loyola, the Arbitrator finds that the back injury was related as there is sufficient, if not perfect, proof of notice of the back injury.

In reaching this assessment the Arbitrator notes Dr. Levin's deposition testimony. Dr. Levin originally opined hat he did not believe Petitioner's low back condition was related to the work-injury from August 25, 2010 (Rx 5 at 34-35). On cross-examination, Dr. Levin was presented with evidence including Petitioner's Exhibit #1, the Employee's Report of Claim as well as the evidence of a possible mistake in Dr. Cammarano's records. After this evidence was presented to him, Dr. Levin testified that, "But there's no question that this, in concert with your other document, if I look at the totality of information, could, in fact, affect my opinion." (Rx 5 at 55).

The causation opinions of Dr. Cammarano and Dr. Fink carry more weight than that of Dr. Levin. Dr. Levin's original opinion is based upon lack of reporting by the Petitioner. During cross examaination, Dr. Levin was provided evidence that Petitioner reported a back injury. When confronted with this evidence, Dr. Levin testified that, "It would influence my opinion" (Rx 5 at 57). As discussed under the accident and causation issue, the Arbitrator finds that there are several crucial pieces of documentary evidence that memorialize Petitioner's claim of back injury. Specifically, Petitioner Exhibit 1 (PX1) which is the Employee's Report of Claim, FMLA report authored and signed by Dr. Cammarano on September 16, 2010 and Dr. Cammarano's Initial Examination/Evaluation Report dated 8/26/10 all document that Petitioner reported a back injury to his employer as well as to his doctors. Dr. Levin's opinion is heavily premised on the belief that Petitioner did not report a back injury for several months. His opinion is conditional and he acknowledged that this opinion would change if provided contrary evidence.

The Arbitrator finds ample contrary evidence that Petitioner reported a back injury within a few days of the incident. Therefore, the Arbitrator finds that the Petitioner

has proven by a preponderance of the evidence that he his low back and right shoulder pains are causally connection to his work-injury.

As to the causal connection between Petitioner's current condition of ill-being, the Arbitrator finds that the Petitioner has failed to prove that his current conditions are related to his accident.

All of the Petitioner's doctors an the IME, Dr. Levine agree that Petitioner has healed from his right shoulder injury and could return to work without restrictions in regards to this condition. As to this low back, IME Dr. Levine found that the back injury was unrelated and that the surgery was not necessary. Dr. Fink performed the outpatient procedure to the Petionerers back and saw him for a follow-up appointment on July, 18, 2012. The Petitioner stated at this time that his back felt great. However he was having unrelated knee issues.

Dr. Fink testified that the knee issues started creating additional issues to Petitioner's treated back and the Petitioner underwent therapy, treatment and medications for his knee issues. Note that Petitioner underwent lumbar spine surgery on July 12, 2012 at Rogers Park One Day Surgery. The pre-operative diagnosis was protruding disc at L4-5 and L3-4 (Pet.Ex.5). Petitioner was seen in follow up on July 18, 2012. His back felt "great" but legs felt heavy. He complained of pain in the right leg.

Petitioner was seen by Dr. Fink and was kept off work. As of the hearing date Petitioner has been unable to return back to work. Dr. Fink testified in his deposition that Petitioner was at MMI for his right shoulder and had plateaued as to his back injury. There is no evidence or testimony from to support that Petitioner was still recovering or off work for his back injury till the date of the hearing. Based on lack of testimony and medical evidence from Dr. Fink and from the Petitioner that the current medical issues are related to the low back injury, the Arbitrator finds that Petitioner's current condition is not causally related. On the contrary the medical documentation from Dr. Fink shows that the back was re-aggravated by the unrelated knee issues.

Therefore the Arbitrator finds that Petitioner's low back and right shoulder injuries are causally connected but that his current condition of ill-being is not related to his accident.

Regarding issue (J), were medical services provided reasonable and necessary, the Arbitrator finds the following:

The Petitioner suffered a work accident and injured his right shoulder and low back. The Respondent does not contest the medical care and treatment relating to the shoulder. As

to the back injury, the Arbitrator has found that the injury was causally related to the work accident. The Petitioner treated with Dr. Fink for his back pain. An MRI that confirmed that the petitioner had supraspinatus tendonitis caused from impingement syndrome. Dr. Fink recommended the outpatient surgery to relieve his pain. An acromioplasty of the right shoulder was performed on February 24, 2011 by Dr. Fink. The procedures performed included an arthroscopic debridement due to a labrum tear, an arthroscopic partial synovectomy, and an open Neer acromioplasty of the right shoulder. The Petitioner subsequently underwent physical therapy and follow up treatment. The Arbitrator finds that the medical services provided to the Petitioner were reasonable and necessary to relieve him of his right shoulder and low back pains and awards the same.

The Petitioner has requested for medical bills of $80,160.00 owed to Dr. Robert Fink; $53,918.44 owed to rogers Park One Day Surgery Center; $8,895 owed to Chatham Advance Pain Relief; $22,553.08 owed to Accelerated Rehabilitation Centers; $3,050.00 owed to Advantage MRI; $1,240.00 owed to Neuromonitoring Services of America; $9,043.02 owed to RX Development; $10,370.50 owed to Industrial Pharmacy Management; $17,900 owed to Dr. John Mazzarella; $2,804.00 owed to Advanced Lab Services and $4,953.94 owed to Prescription Partners.

During the hearing the parties agreed that there are several bills contained in the exhibits relating to the knee surgery. (R. 81) There are other non-relevant bills. Id. Arbitrator Gale at trial requested that the parties delineate the specifics of the bill in the proposed opinions. Id.

The Arbitrator awards the medical bills related to the low back treatment only (The shoulder treatment bills have already been paid and the Arbitrator specifically does not award any bills related to the bladder or knee treatments. The bills regarding the Accelerated Rehabilitation center, the RX Development and the Industrial Pharmacy management do not specify if they are related solely to the back injury as opposed to the other medical issues). Therefore, the Arbitrator does award the medical bill that are reasonable and necessary and subject to the statutory medical fee schedule as they relate to the low back or right shoulder medical treatment. The Arbitrator awards these bill till the MMI date of July 18, 2012.

Regarding issue (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

The Petitioner's received extensive medical care for his right shoulder as well his lower back. During his deposition Dr. Fink testified that he did not wish to opine whether the Petitioner could return to work at this time. Dr. Fink felt that Petitioner "needs the functional capacity exam" for Dr. Fink to make determination of his ability in this regards. (PX3, p. 49) Dr. Fink also stated that he needed Petitioner's job description as well to make this assessment. In terms of Petitioners medical progress regarding his low back, Dr. Fink states that "He's kind of plateaued…so I would say that he's probably going to be at maximum medical improvement to get the functional capacity. (PX3, p. 49) The Petitioner has requested prospective medical care in the form of a discogram and additional medical care per ideas presented in a FCE.

Based on the testimony of Petitioner's treating physician, Dr. Fink the Arbitrator denies the prospective medical care. The Arbitrator finds that the Petitioner is at MMI for all the related work injuries. Petitioner himself told Dr. Fink that he felt "great" in regards to his back surgery. (It should be noted that Petitioner suffered other unrelated injuries and medical issues during the pendency of this case and after his back surgery that may have additionally complicated his return to work.)

Regarding issue (L), what temporary benefits are in dispute, the Arbitrator finds the following:

Having found Petitioner's current condition of ill-being is related to his August 25, 2010 work-injury, he is entitled to any unpaid temporary total disability benefits he should have been paid while he was either authorized off work or released to light duty work which Respondent could or would not accommodate. Petitioner has been off work since August 31, 2010 through the date of trial, January 19, 2016. However, it is the Petitioner's burden to prove that he could not return to work due to work related injuries or medical treatment resulting from the same.

In this case Petitioner underwent lumbar spine surgery on July 12, 2012 at Rogers Park One Day Surgery. The pre-operative diagnosis was protruding disc at L4-5 and L3-4 (Pet.Ex.5). Petitioner was seen in follow up on July 18, 2012. His back felt "great" but legs felt heavy. He complained of pain in the right leg. He was using a walker to ambulate. A post-op brace was given at that time. He was kept off work through August 8, 2012.

Petitioner was seen by Dr. Fink and was kept off work through November 7, 2012. In the interim Petitioner injured his right knee (Per stipulation, said condition is unrelated to his

work injury and Petitioner was treated for his knee condition and kept off work till the present trial date). Dr. Fink testified in his deposition that Petitioner was at MMI for his right shoulder and had plateaued as to his back injury. There is no evidence or testimony from to support that Petitioner was still recovering or off work for his back injury till the date of the hearing.

The outpatient back surgery was on July 12, 2012. This matter was tried in January, 2016. In the Arbitrators humble estimation, this is a lengthy period of time where Dr. Fink gives no opinion or as to whether the Petitioner has recovered from his day surgery. There is very little evidence presented that can help this court find a firm and clear MMI date for the back injury. The Respondent, having denied the back injury, has not sought an opinion on this issue. The matter is further complicated by the Petitioner undergoing treatments for his bladder and knee issues which clearly caused him to be off work. Although the Arbitrator finds that the back injury is causally connected, the Petitioner cannot merely stand on his request for TTD benefits till the trial date. There must be sufficient evidence to show that he was not MMI, that he still needed treatment. The Petitioner has simply failed to so do. In the absence of a clear medical opinion, the Arbitrator looks has looked at the totality of the medical records to find an appropriate MMI date for the back injury. In reaching this assessment the Arbitrator notes that that Petitioner's injury did not compel him to seek treatment for over 7 months. The diagnosis was protruding disc and the surgery was outpatient. Considering the same, the Arbitrator declines to award TTD benefits beyond July 18, 2012 because Petitioner has failed to present sufficient evidence showing entitlement to the same beyond this day.

The Arbitrator also notes that the Petitioner presented no evidence that he had any treatment since August 2015 nor did Petitioner present any off-work slips proving that Petitioner was entitled to TTD benefits from October 9, 2015 through the trial date of January 19, 2016. The Arbitrator also notes that Petitioner did not claim any maintenance benefits on the stipulation sheet.

Based on the evidence presented that as of July 18, 2012, Petitioner was seen in a follow up by Dr. Fink and that his back felt "great". Based on the totality of the medical evidence the Arbitrator finds July 18, 2012 date to be a proper MMI date for the back injury. The Arbitrator finds that the Petitioner's request for TTD for the period through January 19, 2016 (hearing date) to be unreasonable and not supported by the evidence. The Petitioner has failed to meet his burden that he is entitled to TTD for 281 1/7 week.

The Arbitrator finds Petitioner is entitled TTD benefits at the rate of $400 for the period of 8/31/10 through July 18, 2012. (to 97 and 5/7th weeks of temporary disability benefits at the rate of $400.00 totaling $39,084.00.) Respondent is due a credit of $35,509.64.

Regarding issue (O), what vocational assistance benefits should be awarded, the Arbitrator finds the following:

Both Dr. Levin and Dr. Fink opine that Petitioner needs no permanent restrictions for his right shoulder. As to his lower back Petitioner was seen in a follow up by Dr. Fink and that his back felt "great".

Per Petitioner's statements in the lumbar spine FCE, he can do exercises up to 70 pounds until his gallbladder burst and he had abdominal surgery and after his knee surgery. Per the job description of a meat cutter, Petitioner would have only had to lift "up to 20-pound object frequently" and that "product weighing over 50 lbs. is lifted 2-3 times per shift on average" (Resp.Ex.6). Therefore, Petitioner is still able to do his job as a meat cutter. The Arbitrator acknowledges that any current limitations in lifting, due to his unrelated knee and gallbladder issues, may put Petitioner outside his job.

The Arbitrator finds no evidence to support the job description that the FCE examiner utilized. The examiner was under the belief that the Petitioner needed to lift 80 to 100 pounds as part of his job duties. Respondent's Exhibit 6 does it state that Petitioner had to lift 80 to 100 pounds. Additionally, many of the limitations displayed in the FCE are also likely due to Petitioner's unrelated right knee condition.

Lastly, Dr. Fink testified that Petitioner's low back was doing well until he had his unrelated right knee injury which "threw off" his back. He testified Petitioner was using a cane due to his right knee and was on Neurontin due to his right knee. In addition, Dr. Fink testified that Petitioner could work as a meat cutter while on a low dose of Neurontin.

Therefore, the request for vocational assistance is denied.

Regarding issue, what is the nature and extent of the injuries, the Arbitrator finds the following:

This matter was tried as a 19B and an 8A petition. The stipulation by the parties include a request that, if applicable, the Arbitrator rule upon the Nature and extent of the injuries. The parties have not presented an AMA rating and the Petitioner's date of accident is before September 1, 2011. The parties stipulated that Petitioner suffered an injury to his right shoulder on August 25, 2010. He had surgery and failed an FCE study in September of 2011.

Both the treating surgeon, Dr. Fink, and Respondent's IME, Dr. Levin, agree that Petitioner is not in need of any restrictions on his right shoulder. Petitioner testified that he sought no additional treatment for his right shoulder after September 2011. Dr. Levin testified that Petitioner had reached maximum medical improvement for his right shoulder as of June 2011 – less than 1 year from the date of injury. At the time of trial, Petitioner testified that he felt a soreness and ache in his shoulder. Therefore, the Arbitrator awards 12.5% loss use man ($360 x 62.5 weeks = $22,500.00) for Petitioner's operated right shoulder.

As to Petitioner's lumber spine, Petitioner testified at trial that he still experiences lower back pain and that he wishes to continue receiving medical care to help cure that pain. He stated that the shoulder hurts him most when he has to carry groceries. He takes several medications prescribed by Dr. Fink there is little evidence presented by the Petitioner's testimony or the medical records regarding the impact of his low back injury.. In the medical records, Petitioner stated that his back felt great after the surgery. There is little evidence that his back or shoulder issue would cause him an inability to return to work if he did not have other unrelated medical issues. The surgical intervention appear have been successful although Petitioner has some ongoing pain. Dr. Fink felt that Petitioner had plateaued. Based on the finding as to causal connection, the Arbitrator declines to award permanency on Petitioner's lumbar spine. Therefore, the Arbitrator awards 12% of a man ($360 X 60 weeks =$ 21,600.00) for Petitioner's operated lower back.

KSSteffen
Signature of Arbitrator Ketki Shroff Steffen

June 28, 2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAULA LOPEZ,

Petitioner,

vs.

NO: 10 WC 34809

EVANS FOOD PRODUCTS,

Respondent.

18IWCC0581

DECISION AND OPINION ON REVIEW

Petitioner timely filed a Petition for Review of the Decision of the Arbitrator. Respondent, without filing a Petition for Review, filed a Statement of Exceptions to the Decision of the Arbitrator. Notice having been given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary disability, and permanent disability, and being advised of the facts and law, makes the following findings of fact and conclusions of law.

FINDINGS OF FACT:

Petitioner is a Spanish-speaking individual and testified through an interpreter. Petitioner is right-hand dominant and worked as a general laborer for Respondent, a position she held for four-and-a-half years prior to the incident at issue. T. 20, 31. The parties stipulated Petitioner sustained an accidental injury arising out of and in the course of her employment on June 16, 2010. JX1. Petitioner described the incident: "I was working on top of a machine, on a three-step platform. When I was done with the product, I had to go down the steps. As I was going down the steps, I slipped and landed on my buttocks all the way on the ground." T. 19-20. The fall occurred at 6:00 or 7:00 pm; Petitioner testified she was unable to complete the remainder of her shift which was scheduled to end at midnight. T. 21. She reported the accident to her boss, Mr. Carlos, and was directed to the company clinic, MercyWorks. T. 21-22.

Petitioner presented to MercyWorks the next morning and was evaluated by Dr. Gergans.

The records reflect Petitioner complained of pain rated at 6 out of 10 after falling backwards down three steps and landing on her buttocks. After an examination, Dr. Gergans diagnosed contusions to both buttocks; the doctor prescribed Ibuprofen, released Petitioner to full duty, and directed she follow up in 24 hours. PX1.

The following day, June 18, 2010, Petitioner returned to MercyWorks where she was evaluated by Dr. Diadula. Petitioner reported severe pain in her right buttock, lower back, and mid back which radiated to her right calf and foot; she also described numbness and tingling in the right buttock and leg, as well as pain in her right proximal forearm and elbow including the lateral and medial epicondyles and olecranon area. Examination findings included limited lumbar range of motion and positive straight leg raise on the right; x-rays of the lumbar spine and right elbow were negative for fracture. Diagnosing contusions of the right buttock, mid back, and lower back, and right elbow and proximal forearm pain, Dr. Diadula recommended Ibuprofen and warm soaks and imposed work restrictions of no lifting greater than 20 pounds, no repeated bending or twisting, and limited use of the right arm. Petitioner was to return to the clinic the following week. PX1. Petitioner testified she returned to modified duty work after June 18, 2010. T. 42.

Petitioner was not satisfied with the level of care she received at MercyWorks so she sought treatment elsewhere. T. 25. Petitioner testified she attempted to see her regular physician but was told he would not handle workers' compensation injuries; she performed an internet search for doctors who treat work accidents and ultimately made an appointment at Marque Medicos. T. 44.

On July 27, 2010, Petitioner presented to Marque Medicos for a consultation with Fernando Perez, D.C. The record demonstrates Petitioner complained of persistent and frequent lower back pain, persistent but intermittent right elbow pain extending into her right forearm and wrist areas, hand pain especially when clenching her hand to form a fist, intermittent numbness of the right hand and right upper extremity, as well as lesser pain in the right-sided neck area and right shoulder. On examination, Dr. Perez noted tenderness to palpation over the medial, lateral, and posterior aspects of the right elbow, musculature of the right forearm, central and lateral aspects of the right wrist, and central aspect of the right hand; significant tenderness to palpation over the L3-S1 spinal levels, bilateral paraspinal musculature of the thoracic and lumbar spine, right greater than left; moderately decreased and painful thoracolumbar range of motion; right elbow range of motion was full but painful; right wrist range of motion mildly decreased with pain; positive straight leg raise bilaterally, both with positive Bragard's tests; positive Valsalva's maneuver; Mills, Cozen, Tinel's, Phalen's, and Finkelstein's positive on the right; decreased sensation to pinprick over the right C6-8 and right L4-S1; and Petitioner was visibly unable to completely clench her right hand to form a fist due to the pain. Dr. Perez diagnosed lumbar, thoracic, right elbow, and right wrist sprains/strains. He ordered physical therapy as well as chiropractic care and restricted Petitioner to light duty, maximum weight 20 pounds, no overhead use right arm, no repetitive bending or squatting, vary job activities, and sit/stand for comfort. Dr. Perez opined the proposed treatment plan was reasonable and necessary and causally related to the work injury and further noted Petitioner reported she was physically well and working without any difficulties prior to her work accident. PX4.

Petitioner underwent physical therapy and chiropractic treatments over the next two weeks. When she followed up with Dr. Perez on August 13, 2010 she reported her lower back symptoms

and right upper extremity pain persisted, but there had been some improvement in her right upper extremity condition. Dr. Perez noted Petitioner demonstrated improvement, both subjectively and objectively, but had not progressed as anticipated. He ordered MRIs of the lumbar spine, right elbow, and right wrist; in the meantime, Petitioner was to continue physical therapy and remain under work restrictions. Dr. Perez memorialized Respondent was unable to provide an accommodated-position so Petitioner would remain off work. PX3. Petitioner testified she had presented her work restrictions to a manager, Mr. Perez, and he advised there was no job to accommodate her. T. 55.

An August 16, 2010 chart note documents Dr. Perez also ordered an EMG to rule out lumbosacral radiculopathy and/or a right peripheral nerve lesion. PX3. On August 18, 2010, the recommended MRIs were obtained. The radiologist's report of the lumbar spine scan identifies a two-millimeter left neural foraminal protrusion at L5-S1. PX2. The right wrist scan was noted to reveal a tear of the TFC complex near the radial insertion measuring approximately six millimeters in diameter. PX 2. The right elbow MRI was positive for a five-millimeter focus of cartilaginous blistering along the posterior aspect of the capitellar cartilage. PX2.

On August 25, 2010, Dr. Perez re-evaluated Petitioner who reported ongoing lower back, right elbow, and right-hand complaints which had improved somewhat with treatment. Dr. Perez reviewed the MRI reports and opined the positive findings identified therein were clinically significant and "clinically correlated with Petitioner's documented mechanism of injury, as well as her reported subjective complaints and the findings that have been uncovered with the clinical examination performed." He further opined the MRI findings were directly related to the work-related injury. Dr. Perez reiterated his prior recommendation for an EMG and, believing Petitioner's condition required orthopedic and pain management consultations, referred Petitioner to Dr. Ellis Nam for her right upper extremity and Dr. Andrew Engel for pain management for her back. In the interim, Petitioner was to continue therapy. PX3.

On August 26, 2010, Petitioner was evaluated by Dr. Engel of Medicos Pain & Surgical Specialists. Dr. Engel memorialized Petitioner complained of right greater than left radiating low back pain, right wrist and elbow pain, and right-sided neck pain stemming from a fall at work. On examination, the doctor observed left lateral cervical rotation caused contralateral pain, decreased and painful lumbar spine range of motion, tenderness to palpation of the bilateral lumbar paraspinous musculature, and positive straight leg raise on the right which recreated the radicular symptoms; he also reviewed the MRIs. Dr. Engel diagnosed lumbar herniated disc, wrist pain, elbow pain, and cervicalgia, and recommended medication management. Dr. Engel also authorized Petitioner off work "until we are able to define the root cause of her pain." His note further indicates Petitioner denied any low back, wrist, elbow, or neck pain prior to her work-related accident and her mechanism of injury matched her current complaints; he opined the accident was a direct cause of her current pain complaints. PX4.

On August 27, 2010, Dr. Francis McCaffrey conducted a lumbar and right upper extremity EMG/NCV. Dr. McCaffrey's impression was electrophysiologic evidence of a neuropraxic lesion of the median nerve at or about the wrist (carpal tunnel) but no evidence of acute denervation of the lumbosacral nerve roots. The Commission observes Dr. McCaffrey prescribed "round trip non-emergency ground transportation" due to the "complexity and severity of the medical condition."

PX2.

The orthopedic consultation with Dr. Nam occurred on August 30, 2010. Petitioner reported right elbow pain and provided a history of a June 16, 2010 work injury when she slipped down three stairs, "injuring her left [*sic*] hand and then right elbow"; Petitioner indicated the elbow had improved since she had been off work however she was still having pain. Dr. Nam also noted Petitioner "has been treated for left wrist by another physician." After an examination and review of the MRI images, Dr. Nam diagnosed right elbow pain with osteochondral lesion, capitellar region, which he opined was causally related to the work injury. As Petitioner had only recently commenced therapy, Dr. Nam decided to defer additional intervention; Petitioner was to remain off work and continue physical therapy. PX4. Petitioner testified she did not return to see Dr. Nam after this initial evaluation. T. 46-47.

On September 10, 2010, an Application for Adjustment of Claim was filed regarding Petitioner's June 16, 2010 accident. Petitioner testified her then-attorney referred her to Dr. Michel Malek. T. 26, 33, 46.

The initial consultation with Dr. Malek occurred at Advanced Physical Medicine on September 13, 2010. Dr. Malek recorded Petitioner presented for surgical evaluation regarding primary complaints of low back pain radiating down both lower extremities, right worse than left. Petitioner related the symptoms to a fall at work and stated her condition had worsened. On examination, Dr. Malek noted straight leg raise reproducing back pain bilaterally and antalgic gait; the report of the lumbar spine MRI was reviewed. Dr. Malek's diagnoses included status post work injury June 15, 2010 [*sic*]; lumbar musculoligamentous sprain; right elbow pain; bilateral lumbar radiculopathy, clinically in lower lumbar distribution, with preponderance of back pain; MRI scan shows evidence of left neural foraminal protrusion at L5-S1; positive response to therapy; and symptoms at a level patient is not willing or capable of living with. Dr. Malek authorized Petitioner off work, ordered an epidural steroid injection, prescribed pain medications, and recommended continuing with therapy. The record also reflects the doctor's opinion Petitioner's condition was the direct result of the work injury; Dr. Malek noted Petitioner had an underlying degenerative condition that was "silent and asymptomatic and in need of no treatment, but as a result of the injury the condition was rendered symptomatic by precipitation, acceleration or aggravation and in need of treatment." PX10.

Physical therapy commenced at Advanced Physical Medicine on September 14, 2010. The initial evaluation indicates Petitioner complained of low back pain rated at 10/10, radiating bilateral leg pain, and numbness and tingling. PX10.

On September 16, 2010, Dr. Malek performed a bilateral transforaminal epidural steroid injection at L5-S1. PX10. When Petitioner followed up with the doctor on September 27, 2010 she reported an excellent response to the injection for three days, after which the pain returned. Dr. Malek memorialized he reviewed the MRI films and did not see evidence of extruded fragment but did identify dessication and some bulging at L5-S1. Dr. Malek indicated he believed Petitioner's problem was primarily inflammatory in nature, and given her improvement, recommended proceeding with additional injections. If Petitioner improved, a conditioning program and FCE would follow; if she did not improve, discography and/or EMG would be

considered. In the meantime, Petitioner was to remain off work and continue therapy. PX10.

Physical therapy continued as directed and on October 15, 2010, Petitioner underwent a second epidural steroid injection. PX6. She followed up with Dr. Malek on October 25, 2010 and reported she benefitted from the injection but not to the same degree as the prior injection. Dr. Malek recommended proceeding with the third injection and kept Petitioner off work. PX10.

Dr. Malek performed a third epidural steroid injection on November 4, 2010. PX6. Petitioner attended physical therapy over the next two weeks then returned to see Dr. Malek on November 22, 2010. The office note from that date reflects Petitioner's symptoms persisted "at a level she cannot tolerate," with pain down both lower extremities and straight leg raise reproducing her pain bilaterally. Dr. Malek maintained Petitioner's off work status and ordered further workup with an EMG and lumbar discogram. Dr. Malek observed he did not expect Petitioner to be a surgical candidate but recommended discography to rule out a subtle annular tear. PX10.

On November 29, 2010, Petitioner attended a Section 12 examination with Dr. Michael Kornblatt. Petitioner testified she was only with the doctor for three minutes. T. 73. Dr. Kornblatt's report was admitted as an exhibit attached to the doctor's deposition, however the authenticated transcript filed with the Commission only includes pages 2, 4, and 6 of Dr. Kornblatt's report. Our review of the partial report reveals Dr. Kornblatt concluded Petitioner presented without objective findings to justify her significant ongoing subjective complaints. Dr. Kornblatt opined Petitioner was not a surgical candidate; had reached maximum medical improvement regarding the work-related right wrist, right elbow, and lumbosacral strains and contusions; and the only treatment indicated was for her to resume normal activities as soon as possible, including full gainful employment without restrictions. RX1, DepX1. Dr. Kornblatt detailed his findings and conclusions during his deposition, and we will discuss those below.

On December 3, 2010, Petitioner underwent a discogram and post-discogram CT scan. The discogram report indicates the test was valid and demonstrated Petitioner's primary and only pain generator was the L5-S1 level. PX6. The radiologist's impression of the post-discogram CT was abnormal discogram at L5-S1 consistent with annular tear posteriorly on the left, no spinal stenosis, and patent neural foramina. PX2.

Dr. Malek reviewed the discogram results at Petitioner's December 13, 2010 follow-up appointment. He explained Petitioner's options: if her pain was incapacitating, then recommendation would be for lumbar fusion at L5-S1; if not, then there was no need for intervention. Petitioner was to remain off work and consider her options over the next week, then return for further discussion. PX10.

Over the next two months, Petitioner continued with physical therapy. PX10. She next saw Dr. Malek on February 14, 2011, and she stated her symptoms persisted and she wished to "have something done about it." Noting his recommendation was likely to be for a surgical fusion, Dr. Malek ordered an updated MRI and EMG. He also directed Petitioner to remain off work. PX10.

The repeat lumbar MRI was performed on February 19, 2011. Comparing the scan to the 2010 images, the radiologist's impression was stable examination with a two-millimeter left-sided

broad-based protrusion at L5-S1 with no central canal or neural foraminal stenosis. PX2.

Petitioner attended physical therapy over the next four months while approval for the EMG was sought. The EMG was ultimately performed on June 29, 2011 by Dr. Bassam Osman; Dr. Osman's impression was the study was compatible with bilateral L4, L5, and S1 radiculopathy. PX2.

Petitioner continued with physical therapy through mid-September. The September 15, 2011 therapy note reflects Petitioner complained of continuing severe low back pain, bilateral leg pains, and numbness. PX10.

A four-month gap in treatment then occurred before Petitioner was next evaluated by Dr. Malek on February 8, 2012. On that occasion, Dr. Malek noted he had not seen Petitioner since May 23, 2011, but her symptoms reportedly remained "at a level she is not willing or capable of living with." He further noted Petitioner's EMG was compatible with bilateral L4, L5, S1 radiculopathy "objectifying her symptoms." After discussing the options, Dr. Malek recommended another repeat MRI and directed Petitioner to remain off work. PX10.

On March 14, 2012, Petitioner followed up with Dr. Malek. The office note indicates a February 16, 2012 MRI demonstrated evidence of dessication at L5-S1; the Commission observes there is no report from this MRI in the record. Dr. Malek noted he was still awaiting the Section 12 report but stated his recommendation remained the same. PX10.

When Petitioner next saw Dr. Malek on April 11, 2012, she advised her symptoms were unchanged. Petitioner also provided a copy of Dr. Kornblatt's Section 12 report which the doctor reviewed with her. Dr. Malek documented numerous disparities between Petitioner's description of the examination and Dr. Kornblatt's report, including Petitioner's statement that Dr. Kornblatt spent less than five minutes with her; an interpreter was not provided and Petitioner had a significant problem understanding what Dr. Kornblatt was asking; and Dr. Kornblatt's lower extremity exam consisted of testing her reflexes at the knees but not the ankles, and Petitioner "states adamantly that any reference to testing ankle reflexes, the posterior tibial reflexes, any reference to a sensory examination and a Babinski sign, peripheral pulse testing, inspection of range of motion in the back and upper extremity exam is fabricated by Dr. Kornblatt in his assessment under 'Physical Examination' Page 4 and Page 5." Dr. Malek further noted Dr. Kornblatt's report did not address the January 29, 2011 EMG which was compatible with bilateral L4-S1 radiculopathy, and ultimately opined Dr. Kornblatt's opinion was invalid. Dr. Malek recommended Petitioner remain off work while undergoing a four-week conditioning program followed by an FCE. PX10.

Dr. Malek's April 25, 2012 office note indicates Petitioner "tried the conditioning program x 2 sessions. However, her symptoms became incapacitating." The doctor discontinued therapy and ordered an FCE with validity testing. PX10.

The Commission observes there is a disparity between Dr. Malek's records and Petitioner's testimony as to what Dr. Malek's treatment recommendations were as of April 2012. While the records evidence Dr. Malek ordered an FCE, Petitioner testified Dr. Malek wanted to perform

surgery but she declined:

> I asked him, if I was, if I would be able to improve with the surgery. He told me that there was a 70 percent chance that it will not work very well, and 10 percent of possibility that I could end up quadriplegic, and another 20 percent that the pain would become even worse. That's why I did not accept the surgery. That's why I said even with pain, but I was still able to walk and take my children to school. T. 34.

Petitioner was later asked if Dr. Malek indicated any chance of a positive surgical outcome, and she responded, "No, he said only that, he said I don't think that will help you, but if you want to try it - - he left that up to me, to my own decision." T. 50. As to her work capabilities, Petitioner stated Dr. Malek indicated she was not able to go back to work "if they didn't have anything that was less heavy." T. 34-35.

Petitioner did not return to Dr. Malek after April 2012; she explained this was because she was told the doctor moved to another office and then that he retired. T. 50-51. She has not seen any other physician for her low back since April 2012. T. 52.

Petitioner underwent an FCE at Advanced Physical Medicine on May 3, 2012. The job title Laborer, General was noted to be in the Medium strength category; the therapist reported Petitioner did not meet those strength requirements and may not return to work as a Laborer. The therapist further concluded,

> Based on strength classifications as established by the Dictionary of Occupational Titles, Ms. Lopez is currently unable to return to work at any capacity. Her maximum lifting capacity is 5.0 pounds. She is not capable of carrying anything at all. According to the DOT-RFC battery, Ms. Lopez must be capable of meeting the Demand Minimum Functional Capacity for both lifting and carrying strength categories in order to return to work at any capacity.

Under Clinician Comments, the therapist noted, "Patient describes her job as a laborer in a factory that processes food. She stands all during her full-time shift lifting boxes of 20+lbs and pallets of 40+lbs. This FCE reveals patient's inability to stand for extended periods without lower back pain and bilateral leg weakness and paresthesia, and inability to lift, carry, push, pull over 5lbs. Ms. Lopez was in marked discomfort during the examination and had difficulty completing required tasks." PX10. The Commission notes the FCE does not include any validity measurements specific to Petitioner's efforts.

On May 14, 2014, a Stipulation to Substitute Attorney was filed by Petitioner. Petitioner's interests are currently being represented by Goldstein Bender & Romanoff.

Petitioner remained off work until 2015. T. 35. She explained she began actively looking for work at that time because she had to move to a different county after her husband lost his job. T. 35. She started looking for work in June of 2012. T. 36. She worked briefly at a Dollar Tree Store but was unable to continue with the register position because her hand would start to hurt.

T. 36. She worked another job prepping landline telephones for painting; it was a very detailed job and her hand would go numb so she could not do that job. T. 37. She has applied to Target and went to employment agencies. T. 36. She stated it is difficult to find work because general labor requires heavy lifting. T. 36. In the three or four odd jobs she has had the past year, she was earning $8.00 or $9.00 per hour; she was earning $13.00 per hour at Respondent. T. 37. Petitioner is from Mexico and has a sixth-grade education. T. 32. Her vocational history in this country is limited to general labor. T. 32. Petitioner stated she is trying to learn new skills, such as making desserts and fruit arrangements, in case she cannot return to general labor. T. 38. She is taking English and GED classes. T. 38.

The November 7, 2016 evidence deposition of Dr. Kornblatt was admitted as Respondent's Exhibit 1. Dr. Kornblatt specializes in orthopedic surgery, specifically disorders of the spine. RX1, p. 6. In addition to examining Petitioner on November 29, 2010, Dr. Kornblatt reviewed records from MercyWorks, Marque Medicos, the reports of the August 18, 2010 MRIs, the August 27, 2010 EMG, Dr. Nam, and Dr. Malek. RX1, p. 7-8. Dr. Kornblatt obtained the following history from Petitioner:

> On June 16, 2010 she fell down three stairs landing on her low back, buttock, injuring her low back, buttock[,] right dominant upper extremity including the elbow and right wrist. She continued to work for one month, but was then placed on work restrictions by a chiropractor in late July and there were no work restrictions available and therefore she stopped working at that time. She treated with physical therapy from July of 2010. She was performing some stretching exercise a couple of days a week at home. She had undergone three lumbar injections without noting persistent relief. The right elbow was well without pain or feelings of weakness. She complained of right wrist weakness, intermittent numbness. She noted improvement with therapy. Major complaint consists of low back pain, constant, worse with walking greater than ten minutes, bending, twisting and lifting. Noted increase of symptoms with activity. She denied any bowel, bladder incontinence and noted no improvement with the treatment that she had undergone. She was utilizing a pain pill, but didn't know the name and she was also utilizing Naproxen. Past history is negative for previous back injury or similar symptomology. RX1, p. 8-9.

As to his examination findings, Dr. Kornblatt testified there were no abnormal objective findings with the right elbow; there were no abnormal objective findings for the right wrist, although there was some give way weakness muscle testing; and with the lumbar spine, Petitioner had no abnormal objective findings but did have pain behaviors. RX1, p. 9-10. Dr. Kornblatt noted Petitioner exhibited Waddell's signs during his exam. RX1, p. 12-13.

Dr. Kornblatt's diagnoses were right elbow strain contusion resolved, right wrist sprain contusion resolved, and lumbosacral spine strain contusion resolved. RX1, p. 10. The doctor opined Petitioner's treatment prior to his examination was reasonable and necessary. RX1, p. 11. Dr. Kornblatt further opined Petitioner had reached maximum medical improvement, did not require any further treatment, and should have been able to return to her usual job as a meat cutter after November 29, 2010. RX1, p. 11, 14. Dr. Kornblatt testified the June 16, 2010 work accident

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caused Petitioner's condition of ill-being which had resolved prior to when he examined her. RX1, p. 11-12.

On cross-examination, Dr. Kornblatt was presented with medical records for treatment after his examination of Petitioner. The first record was Dr. Malek's November 22, 2010 office note. Asked to state differences between his findings and Dr. Malek's, Dr. Kornblatt responded Dr. Malek "has no finding. He didn't do an examination. So I can't tell you anything about that. There's no examination documented on this, no physical examination." RX1, p. 15-16. Dr. Kornblatt agreed Dr. Malek recorded Petitioner had complaints but explained the generic statement was diagnostically meaningless: "It says persistence of symptoms of a level that patient not willing or capable of living with. What does that mean? I don't know what that means. I have no idea what that means." RX1, p. 17. Dr. Kornblatt was then presented with the discogram and asked if the discogram findings could be accurate; Dr. Kornblatt responded, "He did L4-5 and L5-S1 and L4-5 was normal, as we noted on an MRI scan, and L5-S1 showed some disc degeneration, which was noted on an MRI scan as well. I think it's a worthless test. It means nothing." RX1, p. 18. Asked if the post-discogram CT confirmed the findings, Dr. Kornblatt stated, "It notes findings of very mild disc degeneration at L5-S1, which was what the MRI scan showed." RX1, p. 18. Dr. Kornblatt explained a pain response on discogram is not, by itself, an indication the patient needs surgery; rather, a discogram is one examination to be considered along with all the other information obtained to determine a treatment plan. RX1, p. 27. Directed to the July 29, 2011 EMG, Dr. Kornblatt disagreed with Dr. Osman's interpretation and stated the EMG was normal. RX1, p. 18. The doctor further detailed his concerns with Dr. Malek's records: "...he has a narrative. He doesn't talk about her subjective complaints. He didn't document specific subjective complaints. He didn't document an examination. He documents diagnoses and what he wants to do. That's what he does in his notes." RX1, p. 20.

On re-direct, Dr. Kornblatt reiterated Petitioner displayed Waddell's signs during his examination of her; he further stated her objective findings correlated with the lack of abnormal findings. RX1, p. 28. Dr. Kornblatt testified the records he reviewed during the deposition did not change his opinions. RX1, p. 28.

Petitioner testified she had no problems with her back or right upper extremity prior to the work accident. T. 24. She denied having prior medical treatment to those body parts and stated she has always been very active. T. 33. Petitioner testified she has not had any accidents since June 16, 2010. T. 62.

Describing her current symptoms, Petitioner indicated her back has pain every single day, but the pain is stronger three or four days per week. T. 27-28. The pain affects her a great deal because she is not able to do things she used to do before. T. 28. She can be seated for a while then will need to stand because the pain begins and her legs go numb. T. 28-29. Regarding her elbow, it intermittently hurts a lot; she has to take breaks because her arm goes numb; she has to keep moving the elbow and she does not have a lot of strength in the arm. T. 29. As to her wrist, she has difficulty opening containers because she does not have a lot of strength and when she exerts effort, her hand hurts. T. 30. Petitioner then described how her lifestyle has changed since the accident seven years prior: "It has affected me in everything because before the accident, I was able to go out with my children to ride a bike and now I can't. Before I used to be able to clean my

house and mop, now I'm not able to lift the bucket up. There are many things like chopping for vegetables, I have to take breaks or my sister helps me sometimes." T. 30-31. She reiterated her pain has been constant since her accident, some days worse than others. T. 32.

The Commission observes Petitioner asked to stand/sit on multiple occasions during the hearing. T. 24, 33, 53, 68. Asked to explain why, she stated, "That's because I cannot sit for long periods because my leg started to go numb. I have to be standing up and the same occurs when I'm standing up." T. 83.

We further note Petitioner made a fist with her right hand and then-Arbitrator Simpson made the following observation: "For the record, she has got her little finger, her ring finger, and her middle finger are touching her palm. Her index finger does not, it is resting against her thumb." T. 82-83.

CONCLUSIONS OF LAW:

Causal Connection

Petitioner argues her conditions of ill-being remain causally related to her undisputed work accident. The focus of Petitioner's argument is attacking Dr. Kornblatt's opinion as "illogical," internally "contradictory," and including "misleading information." In response, Respondent asserts Dr. Kornblatt's opinion is persuasive and credible. Respondent further argues "the treating records of Dr. Malek were not even introduced and are not in evidence" and affirmatively states "Arbitrator Carlson had the opportunity to observe the Petitioner's demeanor while she testified" and found Petitioner's complaints not credible. Prior to reaching the merits, the Commission must acknowledge and resolve the apparent confusion the parties have over the procedural history of this claim.

At the time this matter proceeded to hearing, Petitioner's claim was assigned to then-Arbitrator Simpson; the trial commenced before her on February 10, 2017. During this hearing, Petitioner's testimony was taken and the following exhibits were offered and admitted: MercyWorks (PX1), diagnostic reports (PX2), Marque Medicos (PX3), Marque Medicos Pain Surgical Specialists (PX4), Fullerton Surgery Center (PX6), accident report (PX7), medical bills (PX9), and Dr. Kornblatt's deposition (RX1). Petitioner also offered exhibits containing Dr. Malek's records (PX5) and Dr. Malek's work status reports (PX8), however those exhibits were rejected as neither included a certification or subpoena. T. 101. Petitioner does not challenge the propriety of that ruling before us, and we have not considered the contents of the rejected exhibits. The trial was ultimately bifurcated, Arbitrator Simpson noting on the record that proofs were continued so Petitioner could obtain additional records that had been subpoenaed but not yet received. T. 102.

Prior to the continuance date, Arbitrator Simpson was appointed Commissioner and the case was reassigned and a new arbitrator presided over the April 10, 2017 hearing date. On this date, Petitioner offered into evidence Petitioner's Exhibit 10, the medical records and bill from Advanced Physical Medicine; notably, this exhibit contains, *inter alia*, Dr. Malek's treatment records. Respondent did not object to the admissibility of the records, and the exhibit was admitted.

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Proofs were then closed with no testimony being taken that day. The Commission notes there is no indication in the transcript that Petitioner was present on April 10, 2017.

The Arbitrator's decision contains the following findings: "Dr. Malek's records are not in evidence" and "Furthermore, the Arbitrator finds that the subjective complaints of the Petitioner are not credible and appear to be exaggerated based upon the opportunity to observe the demeanor of the Petitioner...." Neither of these statements is compatible with the record. First, Dr. Malek's records are in evidence: Petitioner's Exhibit 10 includes Dr. Malek's treatment records for September 13, 2010 through April 25, 2012. Second, the Arbitrator's adverse credibility determination based on his "personal observations" of Petitioner cannot stand because it does not appear the Arbitrator rendering the decision observed Petitioner: Petitioner testified on only one occasion and that was before Arbitrator Simpson on February 10, 2017. Any credibility determinations set forth below were gleaned from our review of the transcribed testimony as considered in conjunction with the medical records.

Turning to causal connection, we are tasked with weighing the competing conclusions from Dr. Malek and Dr. Kornblatt. Both physicians are well known to the Commission. Dr. Malek's records demonstrate Petitioner underwent conservative care with physical therapy as well as three epidural steroid injections from September through November 2010. As of November 22, 2010, Dr. Malek noted Petitioner's "symptoms persist at a level she cannot tolerate"; with the exception of the statement that the straight leg raise reproduced her pain, the doctor did not document objective examination findings. One week later, Petitioner was examined by Dr. Kornblatt. The doctor's report, partial though it may be, does include a fairly extensive physical examination:

> Examination of the right elbow reveals full range of motion of the right elbow including flexion, extension, pronation, and supination without pain. There is slight tenderness with palpation diffusely of the right elbow including the olecranon, medial, and lateral epicondylar regions. There is no swelling. There are no skin lesions. The elbow is stable to both varus and valgus stresses. Muscle strength about the right upper extremity is grossly intact. Examination of the right wrist reveals full range of motion of the right wrist including dorsiflexion, palmar flexion, racial and ulnar deviation, pronation, and supination. The patient denies pain with range of motion of the right wrist. She complains of pain with light palpation of the whole wrist including dorsal, volar, radial, and ulnar regions. Tinel is negative at the wrist. There is no atrophy involving the thenar eminence or intrinsic. Muscle strength about the intrinsics of the hand is intact. There is give way weakness with muscle testing of the wrist stabilizers. There is no effusion involving the right wrist. There are no skin lesions and no swelling noted. Examination of the lumbosacral spine reveals the patient's spine to be straight. There is no list. Gait is slow in the room. When asked to walk on her toes and heels, the patient exhibits give way weakness of the toe flexors and extensors. The patient is able to squat halfway down while holding onto the examination table. The patient complains of pain with palpation of the skull, right and left trapezius muscles, medial border of both scapulae, right and left lumbar paraspinal muscles, all lumbar spinous.... RX1, DepX1.

During his deposition, Dr. Kornblatt explained Petitioner's examination revealed no abnormal

objective findings for her right elbow, right wrist, or lumbar spine, yet Petitioner displayed pain behaviors and Waddell's signs. RX1, p. 9-10, 12-13.

The Commission finds the absence of objective physical examination findings coupled with positive Waddell's signs as documented by Dr. Kornblatt is significant, particularly when considered in conjunction with Dr. Malek's routine failure to detail specific complaints or physical examination findings. The Commission finds Petitioner's conditions of ill-being reached maximum medical improvement as of November 29, 2010.

Temporary Disability and Medical Expenses

In keeping with our causation and maximum medical improvement determinations, the Commission finds Petitioner is entitled to temporary total disability benefits from July 26, 2010 through November 29, 2010, a period of 18 1/7 weeks, as well as reasonable, necessary, and related medical expenses incurred through November 29, 2010. The Commission specifically declines to award any transportation costs, as we find those neither reasonable or necessary.

Permanent Disability

There are two components to Petitioner's claim: her lumbar spine and her right hand. Regarding her lumbar spine, Petitioner underwent approximately five months of physical therapy combined with a series of epidural steroid injections and, as of November 29, 2010, while her subjective complaints persisted, she had no abnormal findings on examination. We are cognizant of the FCE indicating Petitioner is "unable to return to work in any capacity" and "not capable of lifting anything at all." PX10. However, given the FCE does not include validity testing specific to Petitioner, the Commission finds it not probative, and assigns it no weight. The Commission finds Petitioner's lumbar spine injury resulted in the 5% loss of use of the person as a whole under Section 8(d)2.

As to her right hand, Petitioner underwent only minimal treatment. We believe it significant, however, that her injury rendered her unable to fully form a fist. The Commission finds Petitioner's right hand complaints constitute permanent disability of 5% loss of use of the right hand pursuant to Section 8(e)9.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $341.16 per week for a period of 18 1/7 weeks, representing July 26, 2010 through November 29, 2010, that being the stipulated period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have credit for $6,482.42 in temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $307.04 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the lumbar spine injuries sustained caused the 5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $307.04 per week for a period of 10.25 weeks, as provided in §8(e)9 of the Act, for the

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reason that the wrist injuries sustained caused the 5% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses incurred through November 29, 2010 pursuant to §§8(a) and 8.2 of the Act. Respondent shall have credit for any amounts previously paid, and Respondent shall hold Petitioner harmless for any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j).

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 $10,700.00. 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: SEP 25 2018

L. Elizabeth Coppoletti

LEC/mck

O: 7/25/18

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L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOPEZ, PAULA
Employee/Petitioner

Case# **10WC034809**

EVANS FOOD PRODUCTS
Employer/Respondent

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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:

0226 GOLDSTEIN BENDER & ROMANOFF
JUNIRA A CASTILLO
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

2097 GRANT & FANNING
DANIEL SWANSON
300 S RIVERSIDE PLZ SUITE 2050
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(c)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Paula Lopez,
Employee/Petitioner

v.

Evans Food Products,
Employer/Respondent

Case # **10** WC **34809**

Consolidated cases: _____

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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 **Arbitrator Simpson**, Arbitrator of the Commission, in the city of **Chicago, IL**, on **February 10, 2017 and by Arbitrator Carlson on April 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 _____

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FINDINGS

On **June 16, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$26,610.48**; the average weekly wage was **$511.74**.

On the date of accident, Petitioner was **31** 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 totaling **$40,182.93**.

Respondent shall be given a credit of **$6,482.42 for 19 weeks of TTD, 7/26/10-12/6/10**, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,482.42**.

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 $307.04/week for 25.25 weeks because the injury sustained caused 3% loss of use of the person as a whole under Section 8(d)(2) of the Act and 5% loss of use of the right hand under Section 8(e) of the Act.

Respondent appropriately paid all reasonable and related medical benefits through November 29, 2010. Respondent paid 7 days of temporary total disability benefits after November 29, 2010 and is entitled to a credit of $341.16.

Respondent paid for all medical treatment, $40,182.93, incurred prior to November 29, 2010. All treatment and medical expenses incurred after November 29, 2010 is denied because Petitioner did not meet her burden of proof that treatment was reasonable and related to her June 16, 2010 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.

Signature of Arbitrator

05-03-17
Date

MAY 4 – 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAULA LOPEZ, Petitioner, v. EVANS FOOD PRODUCTS, Respondent.	)	IWCC NO.: 10 WC 34809 18IWCC0581

STATEMENT OF FACTS

The Petitioner, Paula Lopez, testified that on June 16, 2010 she was working for Evans Food Products as a general laborer. She was on top of a machine on a 3-step platform, when she slipped on a piece of chicken skin while going down the steps. She testified that she landed on her buttocks on the ground. The accident occurred at about 6:00 p.m. on June 16, 2010 and the Petitioner's shift ended at midnight. Petitioner testified that she reported the slip and fall accident to her supervisor Carlos at Evans Food Products on June 16, 2010.

The next day the Petitioner went to the MercyWorks Company Clinic where she was given Ibuprofen for the pain and sent back to work full duty. Petitioner testified that she had never had any prior medical history regarding the parts of her body that were injured on June 16, 2010. The diagnosis at MercyWorks consisted of contusion to both buttocks. Petitioner returned on a follow up to MercyWorks on June 18, 2010 and complained of pain in the right forearm and right elbow. X-rays of the lumbar spine and right elbow were obtained. They were noted to be negative for fracture. MercyWorks placed the Petitioner on a restricted duty with a 20-pound lifting restriction.

Petitioner testified that she next sought treatment from Dr. Perez at Marques Medical. Dr. Perez arranged to have an EMG and an MRI performed and prescribed therapy. Petitioner testified that she went to Marques Medical without a referral.

Petitioner was questioned about how the injury affected her lifestyle and everyday life after seven years and she testified that she cannot open containers and is no longer able to go and ride a bike with her children. Additionally, she indicated that she used to be able to clean her house and mop and now she cannot lift up the bucket or chop vegetables. Furthermore the Petitioner testified that she is from Mexico and her work history has consisted of general labor.

Petitioner testified that she started treating with Dr. Malek in April of 2012 on a referral from her first attorney, James Ellis Gumbiner. She testified that she never got a work status report from Dr. Malek. Moreover, the Petitioner testified that Dr. Malek told her that she was not a surgical candidate as there was a 70% chance that surgery would not be successful, a 10% possibility that she could end up being a quadriplegic with another 20% chance that the pain would become even worse. (Trial Transcript at page 34) Petitioner testified that surgery was not an option and that even with pain she preferred to be able to walk and take her children to school. The Petitioner testified that her job search since 2012 was limited because she had to move to a different county because her husband lost his job. She testified that when she applied to different temporary agencies where they found her a job, she was only able to work for one week. Petitioner testified that the job she worked was very detailed and she was not able to continue with the job because her hand would hurt too much. (Trial Transcript at page 35)

Further, the Petitioner testified that she actively started to look for jobs about a year ago beginning in June when the children were on vacation. She indicated that she applied to a Dollar Tree Store as a cashier. She also indicated that she put in an application at Target, but the job required her to lift 35-45 pounds. Petitioner stated in summary that she has applied to some jobs which she was not able to attend and had three or four jobs in the past year. (Trial Transcript at page 36) The jobs that she worked paid approximately $9.00 per hour. The last job that she worked was at a warehouse making pieces for telephone landlines, where she wrapped them in tape, to get the telephone parts ready for a painting process. Petitioner testified that it was a very detailed job and her hand would go numb while working there. She further indicated that her back did not hurt at this job because they had the opportunity to sit down or stand up occasionally. Additionally, Petitioner indicated that she is taking English classes and is also

taking GED classes because if she is not able to do general labor again in the future, she would like to start her own business. (Trial Transcript at page 38)

On cross-examination, the Petitioner reiterated that she went to Marques Medical without a referral, a month after the incident on July 21, 2010 and treated conservatively, principally with Dr. Fernando Perez. Thereafter, the Petitioner indicated that the first time she saw Dr. Malek was on September 13, 2010, after a referral from her attorney James Ellis Gumbiner. Petitioner admitted on cross-examination that she saw Dr. Ellis Nam on August 30, 2010 regarding her right elbow, one time. Petitioner testified that during the course of her treatment with Dr. Malek, she underwent three epidural steroid injections, one every 3 months, to her low back, which only provided temporary relief. Petitioner indicated that every time she went to see Dr. Malek, she would only see him for five minutes and afterward he would hardly speak to her but would dedicate his time to speaking into a tape recorder. (Trial Transcript at page 48) Petitioner testified that Dr. Malek would only ask her how her pain was. Petitioner repeated on cross-examination that Dr. Malek told her there was a 70% chance of surgical failure with a 10% chance that she was going to be a quadriplegic after surgery. She also testified that there was a 20% chance that the pain would get worse after a low back surgery. (Trial Transcript at page 49) Dr. Malek told the Petitioner that he did not feel that surgery would help her. Petitioner admitted on cross-examination the last time she treated or saw Dr. Malek was on April 25, 2012 she testified that she started to search for Dr. Malek but was told that he had moved to another office. However, when she called the other office; *"they told me that Dr. Malek had retired."* (Trial Transcript at page 51) Petitioner admitted that she never saw anybody for her low back after April 25, 2012. Similarly, Petitioner admitted that after August 30, 2010, she did not see any Physicians else for her right hand or right elbow treatment. (Trial Transcript at page 52)

Moreover, on cross-examination, Petitioner admitted that she is not a legal US citizen but is presently involved in the legalization process and has a work permit. Petitioner admitted that she saw Dr. Kornblatt for an Independent Medical Evaluation November 29, 2010.

On re-direct, the Petitioner admitted that she may have applied to 30 job positions but was unable to work at many of them because she did not have her papers, such as the Social Security Card and the work permit, making it impossible to find a job. (Trial Transcript at page 76)

Opposing counsel asked Arbitrator Simpson to take judicial notice of how the Petitioner was holding her hand. Arbitrator Simpson noted; *"right now she is sitting and she has got her hands separated, one is on one leg, one is sitting on top of the other that's what."* (Trial Transcript at page 81)

TESTIMONY OF DR. KORNBLATT

Dr. Kornblatt examined the Petitioner on November 29, 2010. He testified by way of evidence deposition taken on November 7, 2016. Dr. Kornblatt testified that he noted significant Waddell's signs regarding the exam of the lumbar spine. He diagnosed a right elbow strain/contusion resolved, a right wrist strain/contusion resolved and a lumbosacral spine strain/contusion resolved. Dr. Kornblatt opined the Petitioner had reached maximum medical improvement and released her to return to full duty work as of the date of his examination of November 29, 2012. Significantly, Dr. Kornblatt testified and stated in his report that *"orthopedically, the patient presents without objective findings to justify significant ongoing subjective complaints."* (Respondent's Exhibit No. 1, Deposition of Dr. Kornblatt)

Dr. Kornblatt opined the Petitioner's objective findings regarding physical examination of the right wrist do not correlate with her subjective complaints regarding the lumbar spine. The patient presented with significant Waddell's signs including tenderness, regional findings include give-way weakness and over reaction. Dr. Kornblatt testified the patient's subjective complaints regarding the lumbar spine did not correlate with abnormal objective findings.

Regarding treatment, Dr. Kornblatt opined that the patient did warrant a reasonable course of physical therapy regarding the right wrist, elbow and lumbosacral strains and contusions. The Petitioner did not present with surgical lesions involving the right wrist elbow or lumbosacral spine. Dr. Kornblatt testified that the Petitioner should resume her normal activities as soon as

possible including full gainful employment without restrictions. Orthopedically, the Petitioner presented without objective findings to justify significant ongoing subjective complaints. There is no objective medical basis on which to base any further ongoing activity and/or work restrictions. Dr. Kornblatt furthermore opined that the patient may perform all activities that a person of her age and stature should be normally be performing including full gainful employment without restrictions and has reached the condition of maximum medical improvement as the conditions have completely resolved related to her right wrist, right elbow and lumbosacral strains and contusions. (Respondent's Exhibit No. 1, Deposition of Dr. Kornblatt)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR DECISION RELATING TO (F), WHETHER THE PETITIONER'S CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE INJURY AND (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING:

The Petitioner slipped on a chicken skin on June 16, 2010 and fell down three steps landing on her buttocks.

The Petitioner first sought treatment at MercyWorks Occupational Clinic on June 17, 2010. Dr. Gergans at MercyWorks diagnosed the contusion to the buttocks and prescribed Ibuprofen and released the Petitioner to return to work full duty.

On June 18, 2010, the Petitioner returned to MercyWorks and saw Dr. Diadula complaining of right forearm and elbow pain, as well as, right buttocks and low back pain. The Petitioner was restricted by Dr. Diadula to lifting no greater than 20 pounds with no repeated bending, twisting and limited use of the arm. The impression or diagnosis was contusion to the mid back, low back, right elbow and forearm pain. Dr. Diadula prescribed conservative care consisting of Ibuprofen, heat and warm soaks.

A month later, on July 2010, the Petitioner sought treatment on her own, without a referral, to Marques Medical. Dr. Fernando Perez prescribed physical therapy and took multiple x-rays, which were all negative for fracture or dislocation. Petitioner last treated at Marques Medical on August 30, 2010, where she saw Dr. Ellis Nam, complaining of her pain in her right elbow and, for the first time, pain in her left hand.

Thereafter, on September 13, 2010, Petitioner sought a surgical consultation from Dr. Malek on a referral from her former attorney, James Ellis Gumbiner.

Dr. Malek's records are not in evidence. However, the Petitioner testified that Dr. Malek administered three injections to her low back before her last visit with him on April 25, 2012.

Furthermore, Petitioner testified that Dr. Malek told her that she was not a surgical candidate as there was a 70% chance of surgical failure with a 10% chance that surgery would result in her becoming a quadriplegic and another 20% chance that her back pain would be worse.

On November 29, 2010, Petitioner underwent an Independent Medical Examination by Dr. Michael Kornblatt. Dr. Kornblatt opined that *"there are no objective findings to justify the Claimant's ongoing significant subjective complaints."* (Respondent's Exhibit 1) Dr. Kornblatt further advised that the Claimant exhibited significant Waddell's signs regarding the exam of lumbar spine.

The Arbitrator finds the medical opinion of Dr. Kornblatt persuasive and hereby adopts his opinion. The full duty release on November 29, 2010 was proper. Petitioner had reached the condition of maximum medical improvement and could return to work as a general laborer without restrictions. Petitioner's diagnosed strain/contusion to the right elbow, right wrist and lumbosacral spine had completely resolved before Dr. Kornblatt's examination on November 29, 2010. On the date of Dr. Kornblatt's examination, the Petitioner presented without any subjective complaints referable to the right elbow.

Further, Dr. Kornblatt opined that the Petitioner suffered a minor strain to the right wrist at the time of the work injury. An MRI scan of the right wrist visualized a small insignificant focal tear to the triangular fibrocartilage complex, though the intrinsic ligaments of the right wrist were noted to be normal. However, Dr. Kornblatt opined the objective findings did not correlate with her subjective complaints. And the physical examination failed to reveal any surgical abnormalities. The right wrist strain had completely resolved by November 29, 2010. (Respondent's Exhibit No. 1, Dr. Kornblatt Deposition at page 14)

Moreover, Dr. Kornblatt opined that regarding the lumbar spine, the Petitioner presented with significant Waddell's signs including tenderness, regional findings including give-way weakness, and overreaction. Dr. Kornblatt concluded that the Petitioner's subjective complaints did not correlate with abnormal objective findings.

Furthermore, the Arbitrator finds that the subjective complaints of the Petitioner are not credible and appear to be exaggerated based upon the opportunity to observe the demeanor of the Petitioner and the opportunity to consider all the evidence 7 years after the original accident.

Therefore, based on the totality of the facts and circumstances, and especially in light of the opinion of Dr. Kornblatt in his finding that the Petitioner had reached the condition of maximum medical improvement and could return to work as a general laborer as of November 29, 2010, the Arbitrator finds the Petitioner sustained an injury resulting in 3% loss of the use as a person as a whole for a resolved lumbosacral spine strain/contusion and 5% loss of the use of the right hand for a right wrist strain/contusion.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND (J) WERE THE MEDICAL SERVICES REASONABLE AND NECESSARY, THE ARBITRATOR FINDS THE FOLLOWING:

The parties stipulated that Respondent paid the Petitioner 19 weeks of temporary total disability benefits in the amount of $6,482.42 from July 26, 2010 through December 6, 2010. (Arbitrator's Exhibit No. 1)

Additionally, the parties stipulated the Respondent paid $40,182.93 in reasonable related medical expenses incurred prior to November 29, 2010.

On November 29, 2010, Dr. Kornblatt opined that Petitioner had reached maximum medical improvement and could return to work full duty as a general laborer without restrictions. Also, Dr. Kornblatt testified that the treatment and therapy performed and recommended by Dr. Malek after November 29, 2010 is not reasonable or related. (Respondent's Exhibit No. 1, Dr. Kornblatt's Deposition at page 14)

The Arbitrator finds the medical opinion of Dr. Kornblatt persuasive and adopts his opinion. The full duty release on November 29, 2010 was proper. Dr. Kornblatt opined that the Petitioner reached maximum medical improvement regarding treatment for the right wrist, right elbow and lumbosacral strains and contusions as of November 29, 2010. Moreover, Dr. Kornblatt opined that orthopedically, the Petitioner presents without subjective findings to justify significant ongoing subjective complaints and there is no medical basis on which to base any further ongoing activity and/or work restrictions. Therefore, based on the totality of facts and circumstances, the Arbitrator finds that the Petitioner is entitled to 18 of the 19 weeks of TTD that she received from July 26, 2010 through November 29, 2010. The Respondent is entitled to a credit for temporary total disability overpaid for seven days of $341.18.

Additionally, based on the evidence educed at trial, the Arbitrator finds that the medical treatment received and stipulated as paid prior to November 29, 2010 was reasonable and necessary. Conversely, all treatment rendered to the Petitioner after Dr. Kornblatt's November 29, 2010 examination and finding that the Petitioner had reached maximum medical improvement is not reasonable or necessary and therefore is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Long,

Petitioner,

vs.

NO: 16 WC 14813

J & R Tire Services, Inc.,

Respondent.

18IWCC0582

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice provided to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses and prospective medical care 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 an amount of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

The Commission modifies the Arbitrator's Decision to specifically award the following medical bills:
-PX5a: Memorial Hospital Carthage, date of services 11-15-16 for $6,186.50 and 12-28-16 for $2,014.50;
-PX5b: Memorial Medical Clinics, dates of services 4-7-16 for $138.00, 4-19-16 for $138.00, 5-20-16 for $498.00, 6-3-16 for $138.00, 11-10-16 for $145.00 and 11-15-16 for $145.00;
-PX5c: Quincy Medical Group, dates of services 6-20-16 for $264.71, 6-29-16 for $2,064.24, 7-6-16 for $177.16 and 11-2-16 for $279.48;
-PX5d: Wear Drug, prescriptions filled 4-7-16 for $15.30, 5-20-16 for $15.00, 10-5-16 for $15.00, 11-2-16 for $3.22 and 11-2-16 for $15.00.

The total of the above medical expenses is $12,252.11 and the Commission awards same pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act. Respondent shall receive credit for any medical bills paid through its group medical plan for which credit is allowed under §8(j) of the Act and shall hold Petitioner harmless from same. Respondent shall pay for prospective medical treatment including an arthroscopy with subacromial decompression and rotator cuff repair recommended by Dr. Derhake, but only after a return visit to the doctor to determine if surgery is still reasonable and necessary. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's December 5, 2017 decision is modified for the reasons stated herein and otherwise affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $12,252.11 for reasonable, necessary and related medical expenses pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for prospective medical care consisting of an arthroscopy with subacromial decompression and rotator cuff repair recommended by Dr. Derhake, but only after a return visit to the doctor to determine if surgery is still reasonable and necessary, pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 25 2018
LEC/maw
o07/31/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

LONG, MICHELLE
Employee/Petitioner

Case# **16WC014813**

16WC036654

J & R TIRE SERVICES INC
Employer/Respondent

18IWCC0582

On 12/5/2017, 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 1.45% 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:

4342 REHN LAW
JOHN REHN
5 E SIMMONS ST
GALESBURG, IL 61401

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
PO BOX 6199
PEORIA, IL 61601-6199

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michelle Long
Employee/Petitioner

v.

J & R Tire Services, Inc.
Employer/Respondent

Case # 16 WC 14813

Consolidated cases: 16 WC 36654

18IWCC0582

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Quincy**, Illinois, on **October 5, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **04/07/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,806.00** the average weekly wage was **$515.50.**

On the date of accident, Petitioner was **50** years of age, **married,** with 1 dependent child.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 5a, 5b, 5c and 5d, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall receive credit for any medical bills paid by it through its group medical plan for which credit is allowed under Section 8(j) and shall hold Petitioner harmless from same.

Respondent shall authorize and pay for prospective medical treatment including an arthroscopy with subacromial decompression and rotator cuff repair surgery as recommended by Dr. Derhake but only after a return visit to the doctor to determine if surgery is still reasonable and necessary.

In no instance shall this aware 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.

Nancy Lindsay
Signature of Arbitrator

November 30, 2017
Date

DEC 5 - 2017

Michelle Long v. J & R Tire Services, 16 WC 14813 (19(b))

FINGINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

On May 19, 2003, Petitioner presented to the emergency room at McDonough District Hospital reporting that she had fallen off a horse the day before landing on her right shoulder and experiencing pain in her right clavicle. Petitioner was concerned about a possible fracture. Petitioner denied any right arm pain. Her shoulder appeared in joint and there was no AC pain, no scapular pain, no cervical or thoracic spine pain. An x-ray of Petitioner's right shoulder was ordered due to a suspected fractured right clavicle. After the x-ray was performed, the doctor noted that it showed one suspicious area on the clavicle to which Petitioner explained that she might have had an old fractured clavicle but she wasn't sure. She was placed in a splint so that any potential hairline fracture wouldn't slip out of place. She was also given pain medication. Discharge instructions were provided. (RX 5, p. 6))

On May 20, 2013 Petitioner went to the Memorial Medical Clinic complaining of right shoulder pain. The location of the pain was deep and anterior and radiated to her arm and neck. Petitioner stated that the pain initially started several years earlier after falling off a horse; however, it had improved but was now hurting again. Petitioner reported that her discomfort increased with nonspecific arm movements, lifting and repetitive movement. An MRI was ordered (PX 1[1]). Petitioner had fallen off a horse the day before and landed on her right shoulder. She was complaining of right shoulder pain and was noted to have pain in the right clavicle area. There was concern for a fracture and she was tender over the mid-clavicle area. She was diagnosed with a right clavicle fracture and placed in a sling. (RX 1, dep. ex. 2, pp. 3-4)

Petitioner underwent an MRI of her right shoulder on May 23, 2013. By history Petitioner had right shoulder pain for ten years "off and on" and had fallen from a horse "worsened this year with decreasing range of motion." The MRI showed a high-grade partial thickness tear of the supraspinatus tendon with possible small full thickness perforation. There was also a tear of the subscapularis tendon with subluxation of the long head of the biceps tendon, thickening of the subacromial and subdeltoid bursa with decreased fluid which was felt possibly related to extension of fluid from the glenohumeral joint and a small full thickness rotator cuff tear. (RX 1, dep. ex. 2, p. 4; RX 4)

Petitioner was seen by Daveda Voss, a nurse practitioner, on May 31, 2013 with complaints of right shoulder pain located deep and anterior which had started several years earlier but she had also recently fallen off a horse. She described the pain as moderate in severity with intermittent sharpness and aching. Upon examination, she had restrictions with range of motion of her shoulder and tenderness to palpation over the lateral clavicle, acromioclavicular joint, acromion, bicipital groove area, long head of the biceps and subacromial bursa. Petitioner had good shoulder strength. She was diagnosed with right shoulder pain and referred to Dr. Wheeler for an orthopedic examination. (PX 1, RX 1, dep. ex. 2, p. 4)

Petitioner returned to Memorial Medical on June 7th and the records show the shoulder was 90% improved (RX3), but they did refer her to an orthopedic doctor. (RX3) (See also PX 1, p. 71)

[1] Many of the records in PX 1 are also found in RX 3.

Dr. Wheeler examined Petitioner on June 11, 2013. She had a history of having fallen off a horse in 2003 with activity-related right shoulder pain since then. Petitioner had done better with medication. If she overused her shoulder chopping wood, engaging in repetitive lifting, etc. she would notice increased discomfort. Petitioner was working as a cook. On examination, Petitioner had full range of motion, no swelling and no crepitance in her right shoulder. Dr. Wheeler reviewed the MRI of her right shoulder and diagnosed rotator cuff pathology, most likely degenerative, which could be related to the 2003 fall off a horse but it was "difficult to determine." The doctor noted Petitioner was doing reasonably well so he did not recommend surgery as it might not make her any better. She was told to continue using Meloxican. (RX 6)

Petitioner returned to see N.P. Voss on June 18, 2013 regarding blood pressure issues. Petitioner's shoulder was noted to be positive for arthralgia; however, no joint pain or radiculopathy was noted. Treatment plans only addressed Petitioner's hypertension and Petitioner voiced no specific shoulder complaints. (PX 1)

Thereafter, there do not appear to be any further medical records pertaining to treatment or concerns for Petitioner's right shoulder. Petitioner did see her family doctor in June and July of 2013 without complaints of shoulder pain (RX3).

On October 22, 2013 Petitioner saw her primary care provider for blood pressure follow-up and shoulder arthralgia was noted but, again, no treatment to her shoulder was being requested. (RX3) Similarly, in May of 2014, on another blood pressure visit, the provider made a note of pain with range of motion in Petitioner's shoulder; however, he also noted there was no shoulder pain as of the day of the consultation. (RX3)

The records are absent of any orthopedic visits for Petitioner's right shoulder between May of 2014 and 2016 and any visits to the doctor specifically to address complaints of shoulder pain between 2013 and 2016. (RX 3)

On/about September 29, 2014 Petitioner began working for Respondent. Pay records (RX 2) show that Petitioner routinely worked 47 hours per week between April of 2015 and April of 2016. (RX 2)

Petitioner's pharmacy records show no Meloxicam medication refills being provided to Petitioner between February 21, 2014 and April 7, 2016. (PX 5d)

On April 7, 2016, Petitioner saw Tracy Burgurd, a nurse practitioner, at Memorial Medical Clinic for shoulder pain. (PX1) It was noted that the problem had been ongoing for the past year, but the symptoms were progressing and worsening, with Petitioner's right shoulder joint being primarily affected. It was also affecting the right deltoid and aggravating factors were identified as overwork and over exercise. She was prescribed Meloxicam and told to use ice and heat and to return in two weeks if not sooner. (PX1)

On April 19, 2016 Petitioner returned to Memorial Medical Clinic and saw Daveda Voss, a nurse practitioner, for her shoulder pain. Petitioner's symptoms were noted to have been progressive and worsening, and aggravating factors included overwork and exercise. Ms. Voss noted that Petitioner had undergone an MRI 3 years earlier that showed significant shoulder pathology. A decreased range of motion with right shoulder abduction, internal rotation and external rotation were noted. Petitioner was diagnosed with shoulder pain. She was placed on a 10-pound lifting restriction for one week and directed to use ice therapy and heat therapy They discussed a referral to an orthopedist; however, Petitioner had no insurance

and was concerned about paying for her care. They discussed calling patient financial services regarding options. (PX 1)

Petitioner signed her Application for Adjustment of Claim in case # 16 WC 14813 on May 4, 2016 alleging a repetitive shoulder injury. (AX 2)

Petitioner returned and saw Daveda Voss again on May 20, 2016, again complaining of right shoulder pain. It was noted that this has been a "problem for the past worse over last 2 months, 1 + years." Aggravating factors included overwork and over exercise. It was also noted that Petitioner had seen Dr. Wheeler in the past who did not recommend surgery at that time. Petitioner's examination was positive for right shoulder pain and she had hardly any range of motion with constant pain being noted. She was given an injection in her joint and placed on a 25-pound weight limit restriction for two weeks (PX1).

On June 3, 2016, Petitioner returned to Daveda Voss with complaints of right shoulder pain and joint stiffness. Physical examination showed a decreased range of motion with right shoulder and shoulder pain. The recent injection had helped significantly initially and was still helping. Dr. Voss referred Petitioner to an orthopedic doctor, Dr. Dr. Derhake, and kept Petitioner on a 25-pound restriction. (PX 3; RX 3)

On June 20, 2016, Petitioner had an initial consultation with Dr. Dr. Derhake at the Quincy Medical Group. (PX2; RX 7) In a medical questionnaire completed by Petitioner that same day Petitioner indicated that she felt her right shoulder had been severely aggravated doing excessive tire work from January to April of 2016. (RX 7, p. 17) He noted that she had right shoulder pain and weakness and was right hand dominant. It was further noted that she worked as an auto tech for a tire business, and, while she was a trained mechanic, she was now mostly changing lots of tires. It was noted that this was a very heavy lifting job with a lot of physical labor. It was further noted that Petitioner had originally hurt her shoulder back in 2013 and had an MRI scan of the shoulder at that time. The 2013 shoulder injury had been treated conservatively and her symptoms were improving. However, it was noted that over the last six months Petitioner was having worsening pain with symptoms that Petitioner believed had been severely aggravated by the excessive amount of tire work she had been performing from January until the present. Dr. Derhake recorded constant pain at 3 out of 10 that awakened Petitioner from sleep on a nightly basis. She had swelling, numbness, locking, catching and weakness, and the pain was worse with lifting or exercise. He noted that she lacked 90 degrees of terminal abduction on active range of motion testing. He also noted a Popeye deformity on the right. Dr. Derhake recommended a repeat MRI scan to compare to the 2013 MRI.

An MRI was taken on June 29, 2016, which showed a full thickness tear of the lateral supraspinatus tendon (PX2; RX 7). It was also noted that there was tendinosis of the mildly retracted tendon. tendinosis of the anterior infraspinatus, tendinosis and interstitial tearing of the lateral scapularis, and the biceps tendon appeared to be displaced medially from the bicipital groove. Concern over a proximal tear was noted.

Petitioner returned to see Dr. Derhake on July 6, 2016. He described her as having a known history of a full-thickness rotator cuff tear diagnosed back in 2013. She had returned to see him with "continued" pain and symptoms. He wished to repeat MRI to see if she had experienced significant progression of her rotator cuff disease. He noted she worked as a mechanic. His review of the new MRI showed a partial thickness tear of the superior aspect of the subscapularis tendon. He noted a moderate amount of degenerative changes of her AC joint and a significant full thickness rotator cuff tear of the supraspinatus extending into the more medial aspect of the infraspinatus tendon. All in all, he felt the new MRI revealed significant progression of her rotator cuff disease. Dr. Derhake recommended a formal arthroscopy with subacromial decompression and rotator cuff repair. On this visit the doctor noted there was no significant atrophy (PX 1; RX 7).

On October 22 and 24, 2016, Petitioner and Chris Cole communicated with one another via text messages. Petitioner advised Mr. Cole that she "hurt really bad this morning meds not helping won't be in." Mr. Cole replied that the last he knew Petitioner's hand only hurt for a day or two. (PX 7)

On October, 24, 2016, Petitioner received treatment at the Memorial Medical Clinic from a nurse practitioner, Dawn Cousins, for her left thumb. It was noted that the visit was being covered under workers' compensation. (PX1) Records from the visit note that Petitioner was on her knees beating a tire rim with a hammer to loosen it, when the tire came loose and came down on her left hand. She reported pain in the left hand with gripping and extension of the thumb. On examination decreased range of motion was noted in the left thumb with extension along with limited range of motion and grip and muscle strength was recorded at a level of 2 out of 5 in the left thumb. Petitioner's right shoulder examination was positive for arthralgia with aching and some difficulty with range of motion being recorded. Mention was made of a history of osteoarthritis in Petitioner's shoulders. Petitioner was noted to be already receiving treatment for her right shoulder. The doctor diagnosed hand pain and put restrictions in place of no lifting over ten pounds of the right shoulder or left hand until she was medically released. (PX 1)

A CT of Petitioner's left hand was taken on October 24, 2016. According to the report Petitioner dropped a tire and rim on her left hand on September 10, 2016, and had pain at the base of the first metacarpal bone since the trauma on September 10, 2016. No fractures were detected, but effusion was present at the radiocarpal joint (PX3)

On October 24, 2016, Petitioner further advised Mr. Cole, via text message, that "she hadn't been able to take oil caps off without it hurting for a month and better now." Also, "To top it off the doctor said both problems are aggravating each other." (PX 7)

Petitioner was terminated from her employment with Respondent on October 28, 2016.

Surveillance video was taken of Petitioner on October 29 and October 30, 2016. This surveillance video is approximately 41 minutes in length. Petitioner is seen driving a pick-up truck and backing it up to a barn and then removing a tool box from the bed of the truck. (RX 8)

Petitioner returned to Dr. Derhake's office on November 2, 2016, for a pre-operative visit prior to her right shoulder arthroscopy (PX2). At that visit the doctor also noted that there was a possibility of addressing biceps tenodesis for definitive management of the injury. Petitioner was cleared for surgery by Dr. Derhake. However, a pre-surgical EKG came back with an issue in regard to the surgery, which led to additional stress testing and delay prior to scheduled surgery. (PX 1,2)

On November 17, 2016 Petitioner filed her Application for Adjustment of Claim in case #16 WC 36654 alleging left hand and thumb injuries. (AX 4)

On November 16, 2016 Petitioner was again under surveillance. She was filmed sitting in a pick-up truck and smoking a cigarette. She eventually exited the truck and walked into a building. She is then later seen leaving the building and talking with another woman while walking before getting into the truck and leaving. (RX 8)

On December 2, 2016, Petitioner returned to Memorial Medical Clinic where she saw Daveda Voss for her left hand (PX1). The discomfort in her thumb was described as aching, bruised and occasionally

sharp. The doctor noted that the pain was alleviated with rest and aggravated by lifting and twisting and that the initial onset was 12 weeks previously. Upon examination, it was noted that Petitioner was positive for left thumb pain. The exam further noted decreased range of motion of the left thumb with limited range of motion and grip, and muscle strength at a 2 out of 5 level in the left thumb. The records also note that Petitioner was afraid to tell her employer about the injury to her thumb because of the injury to her shoulder, and that she was tearful concerning the same. She was provided with instructions to splint the thumb at night and several times during the day and diagnosed with hand pain with the recommendation to use Tylenol Extra Strength as directed in-between Meloxicam. Petitioner was to return as needed. (PX 1; RX 3, p. 47)

On December 16, 2016 Dr. Lyndon Gross issued a medical report to Respondent based upon a medical records review. He did not examine Petitioner. The report is limited to Petitioner's alleged right shoulder injury. In his report, Dr. Gross stated that he had reviewed the 2013 MRI and 2016 MRI, prior medical records from 2013 and her more recent medical records. He wrote that Petitioner had "an examination and ancillary studies" consistent with a right shoulder rotator cuff tear and a tear of the long head of the proximal biceps tendon. He felt further treatment was appropriate and suggested non-operative non-steroidal anti-inflammatory medication and physical therapy. He was "cautiously optimistic" that the foregoing would be successful due to her continued complaints and pathology. The "more definitive" procedure would be a right shoulder arthroscopy with subacromial decompression and rotator cuff repair which would allow her to have a better chance of having improvement with her shoulder. Dr. Gross felt the 2013 records and MRI showed Petitioner had rotator cuff pathology in her shoulder before her recent injury. He also felt she had had further progression of her rotator cuff disease over the ensuing years and she did not have one specific injury over those years. He felt it was no uncommon for this type of disease to progress over time regardless of activity level and it is more likely that her current situation was a natural progression of her disease than related to any one specific injury. In his opinion, any further treatment would be related to Petitioner's pre-existing condition in her right shoulder. (RX 1, dep. ex. 2)

On February 2, 2017, Dr. Adam Derhake was deposed in regard to Petitioner's shoulder claim. (PX 4) Dr. Derhake practices orthopedic sports medicine surgery (PX4, P4). He has practiced with the Quincy Medical Group since 2009, and he attended medical school at the University of Illinois and did a year of subspecialty training in sports medicine and arthroscopy in Coral Gables, Florida at Doctors Hospital (PX4, pp.4-5). Dr. Derhake first saw Petitioner on June 20, 2016 (PX4, pp. 5-6). Petitioner completed an intake sheet at the doctor's office indicating her shoulder was severely aggravated from doing excess tire work from January 2016 through April 2016 (PX4, p.7). Petitioner explained to the doctor that her injury was from lifting (PX4, p.8). Dr. Derhake took a history from Petitioner noting that she worked as an auto tech for a tire business, that she was a trained mechanic, but was now doing mostly changing of a lot of tires (PX4, p.8). The changing of tires required very heavy lifting and a lot of physical labor (PX4, pp. 8-9). Petitioner also told the doctor that she had hurt her shoulder back in 2013, and that an MRI had been performed back in 2013 (PX4, p.9). As of the initial visit in June 2016, Petitioner reported that over the previous six months she started to have worsening pain and symptoms in her shoulder (PX4, p. 9). She believed her shoulder had been aggravated by the excessive amount of tire work from January until her presentation in June of 2016 (PX4, pp. 9-10). Her pain was constant and awakened her nightly (PX4, p.10). Petitioner stated that the shoulder was worse with lifting (PX4, p.10). She lacked range of motion on her right shoulder (PX4, p.11). She had tenderness to palpation and a Popeye deformity on the right side, which is indicative of a long head of the biceps tendon tear (PX4, p.12). The doctor reviewed the 2013 MRI, and after examining the patient and taking the history, Dr. Derhake testified that he was concerned for a full thickness rotator cuff tear, based on the weakness she was having (PX4, p.13). Dr. Derhake testified that he ordered a new MRI (PX4, p.14).

Dr. Derhake further testified that there was a significant change between the 2016 and 2013 MRI, in that the 2016 MRI showed a complete rupture of the long head of the biceps and a definitive full thickness rotator cuff tear of the supraspinatus tendon with 1 cm of lateral tissue still in the footprint and 1 cm of tendon retraction (PX4, p.15). The doctor testified that due to the full thickness nature of the rotator cuff tear he recommended Petitioner pursue a formal arthroscopy with subacromial decompression and rotator cuff repair (PX4, p.15). Page 16 of the deposition transcript is missing but at the beginning of page 17 there is testimony from the doctor regarding long-term benefits of conservative management. (PX 4, p. 16)

Dr. Derhake testified that he saw Petitioner again on November 2, 2016, when Petitioner was doing essentially the same (PX4, p. 17). Dr. Derhake testified that he believed his treatment to Petitioner was reasonable and necessary (PX4, p.18). Dr. Derhake also believed that the rotator cuff disease that Petitioner had was a result of repetitive lifting (PX4, pp.18-19). He further testified that the MRI findings in 2016 showed an acute, as opposed to a chronic, injury noting that the longer the rotator cuff tendon is torn the more muscle tends to undergo a process called atrophy, and that the evaluation of her MRI scan of 2016 showed she had no significant atrophy throughout her rotator cuff muscles (PX4, p.19). The doctor explained the lack of the loss of a muscle is a sign that this was a recent injury (PX4, p. 20). Dr. Derhake testified that arthroscopic surgery for her shoulder was recommended and appropriate treatment (PX4, p.20).

Dr. Derhake explained that the grand majority of rotator cuff injuries are not from a single event. He explained that the rotator cuff attaches across an area of the bone that is roughly 16 mm wide, and what we see with rotator cuff injuries is that these injuries develop with repetitive use and so we see a whole spectrum of tears all the away from a few millimeters to the complete tendon tears (PX4, p. 20). He explained that the tendon would peel to the bone with repetitive use. He explained that the MRI in 2016 showed that the tendon was completely peeled off the bone. The doctor further explained that in the 2013 MRI there were areas of the tendon that were still attached to the bone (PX4, p.21).

Dr. Derhake could not recall if he furnished Petitioner with any work restrictions. If he did, they were in handwritten form and given to the patient to give to the employer. He thought he probably let her keep on working because he was going to fix it anyway through surgery. (PX 4, p. 23)

On cross-examination Dr. Derhake testified that he felt repetitive activity would be comprised of doing an activity at least fifteen times a day and involving weights in excess of 30 pounds. (PX 4, p.p. 25-26)

The doctor explained atrophy would not happen until the tendon is completely torn off the bone, so atrophy would not start until there was a full thickness tear (PX4, p. 27). He acknowledged that if Petitioner were doing overhead lifting, overhead activities before she went to work for Respondent it was possible "to a certain extent" that those activities could have created the condition of Petitioner's shoulder as shown in the 2016 MRI; however, if one would go too far back before she worked for Respondent ("really anything more than about six months before this MRI") he would have expected the atrophy to start setting in. In Petitioner's case, Dr. Derhake felt her rotator cuff tore completely from the bone between January and June of 2016 (PX4, p. 33). He further testified that he also had to go by Petitioner's report of when her pain and symptoms increased. He acknowledged that he could not recall Petitioner telling him about any other overhead activities or lifting activities she was doing between January and April of 2016. He agreed that chopping wood could tear a rotator cuff completely from the bone and that it was possible, if she was doing that activity between January and April of 2016, that the complete tear was due to chopping wood. (PX 4, p. 34)

On July 14, 2017, Dr. Gross was deposed regarding Petitioner's shoulder claim. Dr. Gross testified consistent with his earlier report. Dr. Gross was asked if he could tell when the rotator cuff completely tore and he replied that he could not. He testified that he knew Petitioner had a tear from the May 23, 2013 injury and it was smaller than what was noted on the 2016 MRI but the 2016 tear was retracted so, obviously, it had some chronicity. (RX 1, p. 14)

Dr. Gross testified that it was his understanding that Petitioner was attributing her rotator cuff tear and proximal biceps tendon tear to her work lifting or changing tires. (RX 1, p. 15) He also testified that splitting or chopping wood could aggravate Petitioner's condition as could lifting 50 pound bags of animal feed. (RX 1, p. 16) Dr. Gross did not believe Petitioner's condition was causally connected to her work duties as "gleaned from the medical records." RX 1, pp. 16-17) Dr. Gross testified that Petitioner's condition was most likely the progression of a normal underlying degenerative process in her rotator cuff. He also testified that such a condition could progress regardless of what she was doing at work. (RX 1, p. 17)

Dr. Gross agreed that the 2013 MRI did not identify a full biceps tendon tear. He also agreed that the 2016 MRI showed a complete tear of Petitioner's biceps tendon (RX1, p. 19). Dr. Gross agreed that there was progression of the tearing of the supraspinatus tendon when the two MRIs were compared (RX 1, p. 19). Dr. Gross testified that it would be reasonable for Petitioner to undergo an arthroscopy with subacromial decompression and rotator cuff repair. Dr. Gross agreed that full thickness rotator cuffs do not heal on their own (RX1, p. 20). With regard to the relationship between chopping wood and lifting feed and the progression of a rotator cuff injury, Dr. Gross explained that depending upon how one would lift the bag of fee it could "fire" the rotator cuff and put tension on it just like with chopping wood. If one is chopping above shoulder level or lifting to waist or shoulder it's going to fire the cuff and stress it, just as with normal activities of daily living and washing one's hair and/or hanging clothes. (RX 1, p. 21) The doctor agreed that lifting something heavy would aggravate or cause progression of a tear. (RX 1, pp. 21-22) He also explained that when he refers to "firing the cuff" he means using the muscles around one's shoulder to lift one's arm. He agreed that lifting a tire could potentially fire the rotator cuff but it would depend on how high one is lifting the tire. Dr. Gross did not know how high Petitioner had to lift tires at her job (RX1, p. 23). If Petitioner was lifting above shoulder level it could potentially cause stress on the rotator cuff and cause progression. (RX 1, pp. 23-24)

On redirect examination Dr. Gross testified that any activity of daily living could potentially progress a shoulder condition to the point surgery is required. When asked if it was impossible to state to a reasonable degree of medical and orthopedic surgical certainty that Petitioner's work duties necessitated the need for surgery, he stated that was correct. (RX 1, p. 26)

Petitioner was again under surveillance on September 25, 2017 and October 2, 2017. The video surveillance is in three parts and covered almost four hours. The first video is approximately one hour and twenty minutes long, the second part is one hour and twenty minutes long, and the third part is one hour and nine minutes long. During these videos Petitioner is seen walking out of a store and then setting up, working at, and tearing down a vegetable stand at a local farmer's market on a square. She gets in and out of her truck, she climbs up on the back of the truck, and she briefly bends over/down and looks under the truck. She also is seen setting up plastic folding tables and organizing and setting out produce in various baskets and bags for purchase. She eats a sandwich, drinks from a plastic container and, occasionally, smokes. She is on her cell phone and goes around speaking with other vendors. She uses both of her upper extremities, including her left hand, with no signs of acute distress. She frequently holds and carries items in her left hand. She occasionally puts one/either arm above shoulder height but not very often. She is seen carrying a

plastic table with her right hand/arm. At one point she and another person carry a table with produce on it a short distance. Her hair was in a pony tail. (RX 8)

Petitioner's case proceeded to arbitration on October 5, 2017. Both of Petitioner's claims were heard by the Arbitrator but the parties understood separate decisions would issue. At the time of the 19(b) hearing in this case, the disputed issues were accident, notice, causal connection, medical bills, and prospective medical care. Barbara Cole was present as Respondent's representative.

Petitioner testified that she lives in Carthage, Illinois. She began working for Respondent on September 29, 2014. She was hired to change oil, do light mechanic work and occasionally help with tires. Respondent is a business that performs services including alignments, brakes and tire work on tractor tires, semi tires, car tires and truck tires. In 2014 most of Petitioner's job involved oil changes, helping out a little bit with "front end stuff" (like power-steering and brake jobs) and, occasionally, helping out with tires (when the two full-time people were busy). The tire work would involve changing, rotating, balancing or repairing tires. Often her work involved work over her shoulders when she had to lift up to change oil filters, remove drain plugs and change belts for vehicles on the hoist or rack. Petitioner explained that when she was performing service work on vehicles it did involve work over her shoulders. The rack didn't exactly go all the way up in the air, especially with pick-up trucks so petitioner was frequently on her knees having to lift up to change oil filters and remove drain plugs. She also had to lift tires during her initial year of working there. She recalled doing so daily because she tried to help out as best she could.

Petitioner testified that she typically worked 47 hours a week when she worked for Respondent and she worked five and a half days a week.

Petitioner testified that in 2015, Tyler Harris, who was a full-time tire mounter, left Respondent's employment leaving the company without a tire mounter. This led Petitioner to doing more tire work in 2015. Petitioner further testified that after Harris left she would do tire work including mounting, balancing and tire repairs. Petitioner explained that when she was doing tire repair work she would take the tire off at ground level. However, a lot of times, if she was in the middle of an oil change, the vehicle would be up in the air, so she would take the tire off and then roll it around and pick it back up and put it on. She would have to change all four tires with a tire rotation. If she was mounting and balancing tires she would have to take them all off, roll them over, pick them up and put them on a machine that takes the tire off the rim. She would then take the tire off the machine, put another tire on, mount it, air it up and take the tire off the machine and then roll it to another machine. At the next machine she would pick the tire up and put it on a machine to balance the tire and she would then have to take the tire off the balancer and take it over to the vehicle and put it back on the vehicle. Petitioner testified that she would have to lift each of the four tires six times for this process. She explained that the tires would be anywhere from 30 to 90 pounds. She stated that she would lift the tires to eye height. She put eye height at 5' and stated that she would only lift tires above her eye height if she were stacking the tires or if they had to put tires away in racks.

Petitioner also testified that in addition to Tyler Harris leaving Respondent's employment, "Lindsay", another tire person, left her tire mounting job at Respondent's business in December 2015. Petitioner testified that after Lindsay left she did a lot more tire work and that's when she started having problems lifting. Petitioner also testified that Respondent only had a part-time tire guy in January. Petitioner testified that she did tires all afternoon, and the tire work started to make her right shoulder hurt. She believed that her shoulder got to be an aggravation probably about the middle of February, after doing the tire work for about six weeks. Petitioner testified that she asked Chris and Jeff Cole, two of her supervisors/bosses, if they were going to hire someone because the tire work was really starting to bother her shoulder. She identified

the three persons in charge of Respondent as Barb Cole and her two sons, Jeff Cole and Chris Cole. The Coles told Petitioner that they were having difficulty finding someone for the tire work, and Petitioner continued to do the job and her shoulder got worse.

Petitioner explained that her shoulder was getting sorer and sorer. She had to pick up her right arm to hold a wrench to get drain plugs and oil filters loose, because it was a pain to get her arm up above her head. She explained that she would lift her right arm with her left hand to get it above her head in order to do her job. She explained that she had to do this with her overhead work at that time, which was mostly oil changes. She said that tire work also bothered her shoulder, and she tried to use her left arm for lifting.

Petitioner testified that at one point she could not get her hair pulled back into a ponytail in the morning because she could not get her arm high enough to do it and that was when she decided to go see the doctor. By that point in time she was having difficulty getting her hair in a ponytail and her shoulder was hurting daily. Petitioner testified that this would have been in March or April of 2016.

Petitioner testified that she saw Tracy Burgurd at Memorial Medical Clinic who examined her shoulder and after Petitioner told Ms. Burgurd that her shoulder felt like there was bone grating on bone, she explained to her that she had ruptured a bursa sac. Petitioner testified that she was told it would heal with time but she needed to take it easy and not lift a bunch of heavy stuff. As a result Petitioner started lifting with her left arm and was able to continue working. However, the pain did not go away and she went back to see Daveda Voss at the Memorial Medical Group, who ultimately gave Petitioner a shot in her shoulder.

Petitioner testified that she told Barb Cole, Chris Cole, and Jeff Cole about her shoulder. She told them about her shoulder right after she got back from the doctor's office visit in April of 2016. She also told the Coles that her shoulder was sore and hurt, and that she believed it was from the excess tire work that she had been doing. Petitioner testified that Ms. Cole did not believe her. Petitioner further testified that she would have told Barb Cole about her shoulder hurting from the excess tire work within two days of (before or after) her April visit to the doctor for her shoulder.

Petitioner also testified that she continued to work after her doctor's appointment with lifting restrictions. Petitioner was able to work with the restriction by using her left hand and getting assistance. Petitioner testified that Chris Cole was very accommodating at making sure she got the extra help she needed.

Petitioner testified that, ultimately, her family doctor referred her to an orthopedic specialist, Dr. Derhake.

Petitioner explained that she did have an MRI of her right shoulder in 2013. In 2013, she did a lot of wood splitting in the winter. Because her home was heated by a wood stove and her husband traveled for work. At that time her shoulder was bothering her, so she went to the doctor, who ordered an MRI. Petitioner saw an orthopedic doctor, Dr. Wheeler, who did not recommend surgery. Petitioner denied any problems with her right shoulder in 2014 and denied requiring any treatment for her right shoulder in 2015.

Petitioner further testified that in 2016 Dr. Derhake ordered a new MRI, and then he recommended surgery. Petitioner testified that she has not yet had surgery. She did start the process of getting ready for surgery and had an EKG done. She had an abnormality that caused her to go through a stress test to make sure her heart could handle the surgery. Ultimately, she was approved for surgery from a physical point of view. Petitioner testified that she has not undergone the surgery which was scheduled for December 1st

because she was fired on October 28th and couldn't save enough money before the scheduled surgery date to pay for insurance to cover the procedure.

Petitioner testified that, currently, her shoulder hurts from time to time, but some days are better than others. When it gets to the point she can't sleep anymore then she will take a Meloxicam to reduce the pain and swelling. She cannot pull her arm away from the back if it is behind her back. Her arm feels like it is starting to go to sleep and is tingling. The feeling of going to sleep and tingling happens three or four times a week. The tingling is in her forearm down to her fingers on the right side of the right upper arm or the pinky finger side. She has daily problems with her shoulder where it hurts although some days are worse than others. Petitioner also testified that her shoulder affects her ability to sleep at night by waking her up. If she gets surgery approved for the shoulder, she will proceed with surgery on her shoulder. She described the day of the hearing as a "good day."

Respondent's counsel cross-examined Petitioner about prior complaints of shoulder pain and prior shoulder treatment. Petitioner acknowledged that in the years leading up to the alleged work accident, and up to the time of trial, Petitioner raised sheep on her property. Twice a week she would purchase 50 lb. bags of food for the sheep utilizing her own pick-up truck. The bags were loaded onto her truck where purchased. Petitioner explained that her husband would unload the bags of feed at her property. Once a day, she would feed and water the sheep. She would carry pails to do this. She rolls 20 lbs. of hay to her animals each day. Petitioner's home requires wood to heat it.

Petitioner also acknowledged that she chopped and stacked wood to heat her home in 2013. She testified to only stacking but not chopping the wood in other years.

Petitioner acknowledged that she has a large garden which she tends to, for the most part, by herself. From July of 2017 through trial, once each week and assuming she has enough produce, Petitioner would sell her produce at a farm stand. She would load the produce to the back of her truck, and unload it at her farm stand in town. She would set up tables and the produce by herself each week. She would rototill her garden. Petitioner performed all household chores herself and was able to do so at the time of trial. She lifts bags of dogfood and carries her own laundry. She's able to do all household chores herself and able to take care of livestock although her husband helps. When asked if all the things she has to do "bug" her shoulder, she replied that they didn't until her shoulder started hurting in 2016 and now they can, depending upon the activity. Petitioner explained that folding laundry can be painful and "flicking" sheets when straightening them bothers her shoulder. Petitioner did not find these activities painful in 2013.

Her hair was in a ponytail at trial.

Petitioner acknowledged that her right shoulder pain in 2013 was waking her up at night. She explained that her shoulder hurt and locked up for about two weeks and so she had to go back to the doctor every two weeks for awhile but then it stopped bothering her anymore and Daveda gave her some Meloxicam to take when her shoulder bothered her. She agreed that in 2013 she used Meloxicam, ice and heat to manage her pain. She doesn't like taking the Meloxicam at the present because it's hard on her liver. She doesn't take it every day. When asked if that was because the pain's not so bad that it's waking her up at night, she replied that it's not so bad that she can't bear it.

Petitioner is currently employed at a grain elevator. She runs the weight scales. Petitioner agreed that she is not under any work restrictions for either her hand or shoulder.

Petitioner also testified that part of her job involved repairing, balancing, rotating and servicing tires on vehicles. The tires would weigh anywhere from 30 to 90 pounds. On September 10, 2016, while at work Petitioner dropped a tire on her left hand. She explained she was underneath a car changing oil that needed to have the tires rotated. She explained aluminum tires have a tendency to seize, so generally you have to beat the tire off with a hammer to at least break them loose so you can get them off. When she hit the tire it came off and bounced back and landed on her left hand. The tire landed on the part of her hand where her thumb meets the wrist or palm. Petitioner testified that she finished the work day, which was on a Saturday and came back to work on Monday, and her hand was kind of stiff and sore. She testified that she let Chris Cole know what had happened to her hand on Saturday and that it was still a little sore.

Petitioner further testified that she did not initially get treatment for her thumb, as she figured it was just bruised. It hurt and it was swollen, but she thought it would go down. The swelling did not go down. Some days it didn't hurt, but the more she did the injured area would swell back up and start hurting again. Ultimately, she saw a doctor on October 24, 2016, at the Memorial Medical Clinic. The doctor ordered a CT to see if there were any fractures, and there were no fractures. Petitioner then followed up after the CT for another visit with Daveda Voss and she was told that she had some badly bruised tendons or ligaments and it might take a month or two to heal. Petitioner testified that she still has problems with the thumb as of the date of the hearing. Her thumb pops, creaks, aches, and hurts. Petitioner testified that she has not gone back to see any doctors because she still does not have any insurance. Petitioner testified that her thumb hurts maybe once or twice a week, and she occasionally still gets swelling in the thumb. She would like to have an orthopedic doctor look at the thumb. She testified that the ongoing problems with her thumb are activity related.

On cross-examination regarding her thumb issues, Petitioner agreed that she was afraid to tell Respondent about her thumb injury because of her shoulder injury. She agreed that the last time she saw a doctor for her thumb was in December of 2016. She agreed that the CT did not show a fracture. Petitioner testified that gripping causes her left hand to swell.

Ms. Cole testified that she is one of Respondent's co-owners. She is the general manager and does bookkeeping and accounting for Respondent. Ms. Cole was asked if there was a time that Petitioner's tire work increased just as she described and Ms. Cole replied that there were occasions when everyone was busy because the entire place was busy. When asked if additional tire work was put on Petitioner's plate Ms. Cole responded by saying "Not on purpose."

Ms. Cole was asked about any conversations she had with Petitioner. Ms. Cole testified that Petitioner told her that her shoulder was bothering her and she was going to go see a doctor about it and then they began getting doctor notes back limiting her weight lifting and everyone tried to accommodate that. Ms. Cole further testified that, one day, Petitioner told her that she and her mother had figured out a way to get her shoulder fixed, by turning it into workers' compensation.

Ms. Cole also testified that Petitioner never told her that her work for Respondent caused her shoulder to hurt. Ms. Cole further testified that she did not know what Petitioner told her about what caused her shoulder to hurt. Ms. Cole testified that when Petitioner began working for Respondent in September of 2014 she became aware that Petitioner was chopping wood at her home to fuel a wood stove. She was also aware of Petitioner's right shoulder being problematic in the past and that she had been involved in an incident with a horse in 2003. Ms. Cole testified that Petitioner performed all of the tasks assigned to her while working for Respondent. Ms. Cole testified that she and Petitioner had concerns about health insurance from a cost perspective.

Ms. Cole admitted that there are people at Respondent's whose primary job was mounting tires, and that at the end of 2015 and the start of 2016 there were personnel changes in the tire mounting work. Ms. Cole testified she was not aware of Petitioner talking to her about the additional work she was doing with tires. Ms. Cole believed that Petitioner would have talked to her sons about the additional work she was doing with tires. Ms. Cole could not remember when the alleged conversation occurred where Petitioner told her that she had figured out a way to get her shoulder fixed. She was not sure if the conversation about fixing the shoulder occurred in 2016. Ms. Cole claimed that there was a later conversation when Petitioner told Cole that Petitioner did not hurt her shoulder at work, but that Petitioner hurt her shoulder falling off a horse.

Ms. Cole explained that either Jeff Cole or Chris Cole would have been the ones who Petitioner told about her hand injury. She stated that they did not fill out an incident report at Respondent's office due to the hand injury because they did not know what to put down and it was an insignificant happening. Ms. Cole did not talk to Petitioner about the hand injury and could not recall if she tried to get information to fill out a report from Petitioner. Ms. Cole stated that she would have been Petitioner's boss during the time Petitioner would have any conversations with her. Ms. Cole agreed that any paperwork from a doctor's office with respect to accommodations came to her. When asked if the initial work restrictions or medical records that Petitioner brought in said anything about a work injury Ms. Cole replied that they just said she had shoulder pain and needed to have restrictions on lifting to allow it to heal.

Christopher Thomas, a private investigator, also testified. Mr. Thomas testified he was retained to conduct surveillance on October 29, 2016. (The video put in as RX 8 shows he took video of Petitioner on three days, including October 29.) Mr. Thomas said he took a video of Petitioner moving a toolbox from her truck. She had her hair in a ponytail. Mr. Thomas videotaped Petitioner for 10 minutes and he testified that he observed Petitioner for eight hours that day. The video shows Petitioner taking several minutes to maneuver a tool box off the back of a pickup truck (RX 8). Mr. Thomas did not have any idea if there was anything inside the toolbox when it was being removed. Mr. Thomas further testified that additional video found in PX 8 reflected Petitioner's activities at a vegetable stand. The video of those activities was not shown during the hearing as Petitioner's attorney did not wish to see the whole video at that time.

Petitioner was recalled and she stated that the toolbox was empty at the time it was removed from the truck. Petitioner explained that the toolbox in her truck got loaded into her truck on October 28th (the day she was fired by Respondent), the day before surveillance. She further testified that Jeff Cole told her she was fired and she needed to pack up her toolbox and leave. She then informed Jeff Cole that she couldn't lift the toolbox by herself and she needed some help. The video was taken on the 29th. It was on the 28th that Jeff Cole fired her.

Petitioner also testified that her visits for her shoulder in April and May were on her dime because her Blue Cross/Blue Shield insurance didn't go into effect until June 1st. When asked if she had a conversation with Ms. Cole about turning her shoulder injury into workers' compensation so it would be free, Petitioner replied, "No, that is not true." Petitioner reiterated that she spoke with Ms. Cole about her shoulder, told her she believed it was due to tire work, and that she felt it should be turned in to workers' compensation. That conversation was held before June 1, 2016. Petitioner also testified that during that conversation Ms. Cole told her she would be very upset if she filed a workmen's comp claim and if her shoulder was bothering her because of her job perhaps she should go look for a different line of work. Petitioner told Ms. Cole that she liked her job to which Ms. Cole replied that maybe she should get

insurance. Petitioner then felt "pretty much forced" to get Blue Cross/Blue Shield insurance to get her shoulder looked at.

Petitioner's medical bills are found in PX 5, 5(a) – 5(d).

Proofs were closed.

The Arbitrator concludes:

I. Issue (C) Accident.
II. Issue (F) Causal Connection.

Petitioner sustained an accident on April 7, 2016 that arose out of and in the course of her employment with Respondent and she also proved that her current condition of ill-being in her right shoulder is causally related to that accident and her employment duties for Respondent. In so concluding the Arbitrator relies upon the credible testimony of Petitioner and the more persuasive opinion of Dr. Derhake, Petitioner's treating physician, over that of Dr. Gross, Respondent's examining physician.

First, the Arbitrator addresses the credibility of the two primary witnesses, Petitioner and Barbara Cole. The Arbitrator specifically finds Petitioner to be the more credible of the two witnesses. The Arbitrator had the opportunity to observe the demeanor of both witnesses while testifying. She found it very significant that Petitioner both spoke to and looked at the Arbitrator while testifying and that, in contrast, Ms. Cole did neither. Additionally, the Arbitrator found Petitioner's testimony more direct, forthright, and complete in detail than that of Ms. Cole, whose answers to questions were often vague and far less specific in detail than that of Petitioner's. Ms. Cole also testified that Petitioner was, at all times, able to perform all of her job duties for Respondent. However, she then contradicted herself by acknowledging that Petitioner needed work restrictions for her right shoulder and that Respondent accommodated them. The Arbitrator has also considered the fact that Petitioner was wearing a ponytail on the day of trial and was also doing same during some of the surveillance. She does not find this undermining of her credibility as she never testified that she is altogether unable to put her hair in a ponytail; rather, she testified that at one point she was unable to get her hair into a ponytail and that is when she sought medical care for her shoulder. That testimony doesn't mean she could not later put her hair into a ponytail.

The unrebutted evidence shows that Petitioner performed repair work on vehicles, which involved overhead work servicing cars and engaging in tire work. The tire work involved repeated lifting of tires that weighed 30-90 pounds. Respondent had two full-time tire mounters that left their employment with Respondent at the end of 2015 and the start of 2016, which led to Petitioner doing more tire work. The increased tire work in the early months of 2016 aggravated Petitioner's shoulder, ultimately causing her to seek medical treatment. By April of 2016, Petitioner could no Petitioner lift her right arm over her head without using her left hand to lift the arm. Petitioner's testimony about her job duties and the onset of her complaints and difficulties was credible. Neither Jeff Cole or Chris Cole testified in rebuttal to any of Petitioner's testimony.

Petitioner sought medical treatment on April 7, 2016. While she did not specifically reference her job duties for Respondent as the link to her symptoms, she did report that overwork was an aggravating factor. Similarly, when she saw Daveda Voss on April 19, 2016 she was placed on work restrictions and, again, aggravating factors were noted to include "overwork."

It is clear that Petitioner had prior right shoulder problems for which she underwent an MRI in 2013 that showed a partial tear of the tendon in her rotator cuff. It is equally clear that she did not have any orthopedic treatment for her shoulder during 2014 or 2015 nor had surgery been recommended prior to the accident herein. While Respondent placed great significance upon Petitioner's 2003 fall from a horse, the medical records (and Petitioner's testimony) are less clear as to whether or not Petitioner truly injured her shoulder in that fall. Rather, she possibly fractured her clavicle. No treatment was rendered to her shoulder at that time. She was treated with a sling for the clavicle injury. Petitioner did receive treatment for her right shoulder during 2013 but, again, she had no treatment in 2014 or 2015 and, at no time, was surgery recommended.

In the years leading up to the alleged work accident Petitioner raised sheep on her property. Twice a week she would purchase 50 lb. bags of food for the sheep utilizing her own pickup truck; however, the bags were put in the truck for her and her husband would unload the bags of feed at her property. Once a day, she would feed and water the sheep. She would carry pails to do this. She rolled 20 lbs. of hay to her animals each day. Petitioner's home requires wood to heat it. Petitioner chopped and stacked wood to heat her home in 2013. She testified to only stacking but not chopping the wood in other years as they have been purchasing it. She testified that stacking wood didn't bother her shoulder. Petitioner has a large garden which she tended, for the most part, by herself. Petitioner testified that she had no difficulties engaging in these activities until her shoulder began bothering her in early 2016.

Dr. Derhake explained how repetitive heavy lifting would cause the strands in the tendon to tear away from the shoulder and cause a complete tear of the supraspinatus tendon and Dr. Derhake related Petitioner's complete tear of the supraspinatus tendon to her lifting at work/ auto tech work for Respondent. While he acknowledged that chopping wood is a type of activity that could cause a rotator cuff tear and that if she had been doing that between January and June of 2016 that activity could "possibly" have caused the progression of Petitioner's rotator cuff disease, no evidence was presented showing that Petitioner was chopping wood during that time frame. She acknowledged, at trial, that she may have been stacking wood but Dr. Derhake was not asked about that activity and its role, if any, in the progression of her shoulder condition.

The MRI in 2016 showed an acute, as opposed to chronic, injury. Dr. Derhake noted that the longer the rotator cuff tendon is torn completely, the more the muscle tends to undergo a process called atrophy, and that the evaluation of the MRI scan of 2016 showed no significant atrophy throughout her rotator cuff muscles. Dr. Derhake explained the lack of atrophy on the torn tendon supported the conclusion the complete tear of the rotator cuff occurred in 2016.

Dr. Gross, the IME doctor for Respondent, said the tear was unrelated to Petitioner's work. However, Dr. Gross did not examine Petitioner as part of the IME process or take a history from her. In his deposition he agreed that there was significant progression of the rotator cuff tear between 2013 when there was a partial tear and 2016 when there was a complete tear. Not only has there been progression of a tear but Petitioner also has evidence of a biceps tendon injury. He agreed surgery was necessary. Interestingly, Respondent had video surveillance of Petitioner by the time of the records review and, yet, did not ask the doctor to comment upon it. Additionally, the doctor was never asked about the matter of aggravation.

While Petitioner has not sought medical treatment for her right shoulder in almost one year, the Arbitrator does not view this lack of treatment as indicative ofa lack of ongoing causation. Petitioner has been without personal means to afford medical care since being terminated by Respondent. Depositions were taken in this case during 2017 so that a 19(b) hearing could be held.

Petitioner's current pain is different than her pain in 2013. Petitioner credibly explained why she limits her use of pain medication and Petitioner, through her testimony and medical records, credibly exhibited a higher tolerance for pain than others might have. Respondent has terminated her and provided her with no benefits regarding this claim. Petitioner has had no alternative but to try and keep moving forward with life and work – albeit with pain depending upon her level of activity. No credible evidence was presented by Respondent suggesting that Petitioner has been able to engage in any activities, at home, at a vegetable stand, or at work, as physically challenging to her right shoulder as what she was doing for Respondent. The Arbitrator viewed the video (RX 8) in its entirety and while it does show Petitioner using her right arm at times and for a variety of activities with seemingly no pain or distress, none of the activities mirrored what she had previously been doing for Respondent on a repeated basis. Petitioner also testified that she has good and bad days and occasionally she has right shoulder symptoms and complaints connected to her operation of a farm stand and/or picking green beans out of the garden.

It is axiomatic that an employer takes its employees as it finds them. *Sisbro, Inc, v. Indus'l Comm'n 207 Il2d 193 205 (2003), Schroeder v. Ill. Workers' Comp. Comm'n 2017 Il App (4th) 160192WC, 79 N.E.3d 833, 839-40 (2017).* Moreover, if the evidence indicates that the work accident increased the petitioner's symptoms, aggravated a pre-existing condition, or accelerated the need for surgery, the condition and need for surgery is causally related to the work accident. *Schroeder at 840-1.*

Petitioner had a pre-existing condition in her right shoulder; however, her work duties for Respondent resulted in an aggravation and progression of that condition. Under Illinois law, Petitioner's job duties for Respondent need not be the only cause for there to be liability. If it is "a" cause, as here, liability has been established.

III. Issue (E) Notice

Petitioner gave timely notice of her accident to Respondent. Petitioner's accident date is April 7, 2016. Under the Act she is required to give notice within 45 days of her accident. Petitioner signed her Application for Adjustment of Claim on May 4, 2016. It was mailed to Respondent on May 6, 2016. The Application alleges a shoulder injury due to repetitive use of her shoulders while changing tires. Notice was timely.

In addition, Petitioner testified that within two days of the visit to the doctor she spoke to Barb Cole, an owner of Respondent and a supervisor of Petitioner, and told Ms. Cole about the shoulder injury and that Petitioner believed the shoulder problem was related to the lifting of tires at her job with Respondent.

Petitioner further testified that she also told Jeff Cole and Chris Cole, two of her other supervisors, about the right shoulder injury and its relation to the work lifting tires at or about the time she was suffering from the shoulder injury in early 2016. Neither Chris Cole nor Jeff Cole testified, and Barbara Cole, while denying Petitioner stated anything to her, provided testimony suggesting that she agreed that Petitioner would have likely told Jeff and Chris Cole about her injuries.

Ms. Cole further claimed that she was never told of an injury at work by Petitioner; rather, she claims that Petitioner told her that she did not get hurt at work but had figured out a way to get her shoulder fixed by claiming it had been injured at work. Ms. Cole could not remember when this conversation occurred. Noting her concerns about Ms. Cole's overall credibility as stated above, the Arbitrator did not find this testimony credible.

IV. Issue (J) Medical Bills.

Petitioner is awarded the medical bills found in PX 5 (and itemized in PX 5(a) through 5(d)). Consistent with her liability determination set forth above (and which is incorporated herein by reference) the Arbitrator concludes that all of the medical treatment provided to Petitioner was causally related to the accident of April 7, 2016, and Respondent is liable to payment of the medical bills incurred herewith as identified in Petitioner's Exhibit 5. Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 5a, 5b, 5c and 5d, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule.

V. Issue (K) Prospective Medical Care.

The evidence shows that in the years leading up to her work accident, and up to the time of arbitration, Petitioner has raised sheep on her property. Twice a week she would purchase 50 lb. bags of food for the sheep utilizing her own pickup truck. She would unload the bags of feed at her property. Once a day, she would feed and water the sheep. She would carry pails to do this. She rolls 20 lbs. of hay to her animals each day. Petitioner's home requires wood to heat it. Petitioner chopped and stacked wood to heat her home in 2013. She testified to only stacking but not chopping the wood in other years. Petitioner has a large garden which she tended, for the most part, by herself. Petitioner testified that she rototills her garden, sets up her vegetable stand to sell produce each week, when possible, during the summer and fall months, performs all household chores primarily by herself and cares for livestock. She also testified that that all of these things can "bug" her shoulder but didn't do so before the early part of 2016. She is employed at a grain elevator running the weight scales. No evidence was presented that this job entails problematic shoulder work.

Petitioner also testified that her shoulder may still wake her up with pain but she manages it as she used to – Meloxicam and ice. However, she further testified that she tries to lessen how often she takes the Meloxicam due to its effect on her liver. She did not testify that her current night time pain is not as bad as in 2013. She testified that the pain is not so bad that "she cannot bear it." Petitioner also credibly testified that her shoulder currently hurts "from time to time" and some days are better than others. Petitioner testified that she cannot pull her arm away from back if it is behind her back. None of the surveillance video contradicts that testimony. Petitioner is trying to remain as fully functional as possible under the circumstances; however, she is not back to her baseline condition as there has been an objective progression of her right shoulder disease.

Petitioner has not seen Dr. Derhake since December 2, 2016. At that point in time, Petitioner was not even two months post her termination with Respondent. Dr. Derhake recommended surgery and has continued to so recommend it. However, he has not examined Petitioner since December 2, 2016. He is unaware that she no longer works for Respondent and is not engaged in the repetitive activity she once was. He is not aware of how she is presently doing and perhaps surgery is not as necessary as it once was. As such, the Arbitrator feels it is more appropriate to authorize a return visit to Dr. Derhake to determine if surgery is still necessary. If so, surgery should be authorized.

Accordingly, Petitioner is awarded prospective medical treatment in the form of right shoulder surgery but only if is still deemed reasonable and necessary by Dr. Derhake after returning to see him. If so, it shall be paid by Respondent.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis Austin,
Petitioner,

18IWCC0583

vs.

NO: 17 WC 21720

SOI/Vienna Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and 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, 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, 2018, 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: SEP 25 2018
o9/20/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0583

AUSTIN, DENNIS
Employee/Petitioner

Case# **17WC021720**

SOI/VIENNA CORRECTIONAL CENTER
Employer/Respondent

On 4/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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

APR 4 - 2018

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

18IWCC0583

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

DENNIS AUSTIN
Employee/Petitioner

v.

STATE OF ILLINOIS/ VIENNA CORRECTIONAL CENTER
Employer/Respondent

Case # 17 WC 21720

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 14, 2018**. By stipulation, the parties agree:

On the date of accident, **March 16, 2017**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$89,357.84**, and the average weekly wage was **$1,718.42**.

At the time of injury, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent. Respondent and Petitioner stipulated that Respondent would pay, or has paid, all reasonable, necessary and causally related medical bills incurred by Petitioner as found in Petitioner's Exhibit 1, that Respondent shall pay same pursuant to the Medical Fee Schedule, and that Respondent shall receive credit for any and all payments made by it or its group medical plan for which credit is allowed under Section 8(j) of the Act and with Respondent holding Petitioner harmless from liability for any bills for which it is receiving this credit.

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

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

ORDER

Respondent shall pay Petitioner the sum of **$775.18/week** for a further period of **37.625 weeks**, as provided in Section **8(e)** of the Act, because the injuries sustained caused the **17.5% loss of use of the left leg**.

Respondent shall pay Petitioner compensation that has accrued from **March 16, 2017,** through **March 14, 2018**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 30, 2018
Date

APR 4 - 2018

Dennis Austin v. SOI/Vienna Correctional Center, 17 WC 21720

FINDINGS OF FACT and CONCLUSIONS OF LAW REGARDING THE NATURE AND EXTENT OF PETITIONER'S INJURY

The Arbitrator finds:

Petitioner was involved in an undisputed accident on March 16, 2017, while in the course and scope of his employment as a stationary fireman and trying to discover why a boiler in the power house was losing steam. As he was climbing over piping in a dark, steam filled room, the pipes rolled and he injured his left knee. Petitioner had sustained no injuries and sought no treatment for his left knee prior to this accident.

Following the accident, Petitioner sought care and treatment from his primary care physician, Dr. Rider, at Primary Care Group on March 17, 2017, where a consistent history of the accident was taken and symptoms of pain and swelling of the left knee were noted. He had been using a cane for walking since the accident. Petitioner was given Tramadol. (PX 3)

Petitioner returned to Dr. Rider's office on March 22, 2017, with persistent symptoms of knee pain, swelling, decreased range of motion, difficulty bearing weight, and difficulty ambulating. When x-rays were benign, an MRI was recommended and Petitioner was referred to Dr. Kevin Koth for orthopedic evaluation. (PX 3)

The MRI was completed on March 27, 2017. It showed a radial tear of the medial meniscus posterior root attachment, a complex tear of the medial meniscus posterior horn, an oblique horizontal partial thickness flap tear of the body communicating with the inferior surface, a small free edge radial tear of the anterior horn of the medial meniscus, strains of the MCL and LCL at their femoral attachments, quadriceps and patellar tendinosis, small joint effusion, and other related positive findings about the medial and lateral femoral tibial compartments. (PX 3)

Petitioner came under the care of Dr. Kevin Koth on April 13, 2017 at which time he reported symptoms of instability in addition to the persistent pain and tenderness. After reviewing the MRI which he described as showing the meniscal tearing with "quite a bit of inflammation" and some mild osteoarthritis in the kneecap, Dr. Koth recommended surgery and explained to Petitioner that the arthroscopic surgery could aggravate the arthritis but the radiographs only showed mild patellofemoral arthritis. (PX 5)

Surgery was performed at Herrin Hospital on May 19, 2017, and consisted of left knee partial medial meniscectomy with medial shelf plica resection and removal of a sizable loose body. Petitioner testified that surgery improved his condition. (PX 5, PX 6)

Follow up visits with Dr. Koth ensued. As of June 1, 2017, Petitioner was reporting he was feeling better each day and was pleased with the outcome of surgery. He doing most everything he needed to do at home in order to get around. He still felt a slight tight feeling when flexing his knee back in full extension. He had not required the use of his walker after three days. Petitioner did report that he wasn't feeling safe with activities such as climbing and his knee would swell if he was very active during the day. Physical therapy was ordered as Petitioner needed 100% use of his knee in his work environment which included using multiple stairs. He was released to sit down duties only. (PX 5)

Dr. Rider's notes indicate a prescription for Tramadol was prescribed on June 12, 2017. (PX 3)

Petitioner returned to see Dr. Koth on July 6, 2017 reporting he was doing well after therapy and was happy with his progress. Petitioner was not voicing any current complaints of pain or swelling. He expressed readiness to return to work. Petitioner was to continue with his home exercises and return in one month for an anticipated full release. (PX 5)

Petitioner returned to Dr. Koth on August 3, 2017. Petitioner reported that he had returned to work without restrictions and was doing fine. Petitioner's left knee exam showed normal range of motion, no redness, swelling, bruising, tenderness, deformity, bogginess, effusion, crepitus, laxity or contracture. The arthroscopic portals on the left knee were well healed. Dr. Koth noted Petitioner was "doing great at this point in time." He had "good strength and motion of his knee. "He is not having any problems." Dr. Koth noted Petitioner could return to work without restrictions as he had reached MMI. He could return as needed. (PX 5)

Petitioner's case proceeded to arbitration on March 14, 2018. At the time of hearing Respondent stipulated that it would pay all causally related medical bills as set forth in PX 1 subject to the Medical Fee Schedule and if not already paid by it or its group medical plan. Respondent further agreed to hold Petitioner harmless from liability for same in exchange for the 8(j) credit. Petitioner was the sole witness testifying at the hearing. Respondent did not have a representative present.

Petitioner testified that surgery improved his condition. He further testified that despite the improvement from the surgery, he continues to experience soreness, stiffness, and occasional swelling in his left knee. He testified that the more he is on his feet at work "running up and down steps or climbing ladders" the more pain and stiffness he has in his left knee. He does not kneel and he has difficulty squatting for very long. He testified to difficulty performing other job duties such as getting down low to the floor to inspect and transfer water pumps. Petitioner further testified to stiffness and pain in his left knee that increases with the length of the shift and the longer the shift goes, then his right knee begins hurting. He has no assistance available to him to perform this duty. He uses Tramadol prescribed by Dr. Rider to alleviate his symptoms. His hobby of working on his farm has been adversely affected by his injury as his farm is located in the hills

of Hardin County. He has to be careful about what he does and it hurts quite a bit climbing up and down off equipment and walking the farm checking fences and cattle. By the time he is done he usually needs a pain pill.

On cross-examination Petitioner testified that he has worked for the Dep't. of Corrections twelve years. He has three years to go before he hopes to retire at age 66. Before he worked for the State, he did construction. He underwent no special certification or training to be a stationary fireman other than what he was taught on the job. He works the midnight shift.

Petitioner testified that he has no helpers for pipe work. Petitioner acknowledged that when he last saw Dr. Koth he told him he wasn't having any problems. He understood the doctor would see him again if he had problems. Petitioner doesn't wear a leg brace at work. He has had performance evaluations since returning to work after his surgery and nothing negative has come up.

Petitioner agreed that his left knee now feels more stable. He does have a little swelling every once in a while. His hobbies include hunting, camping, and hiking. He hunts deer and turkey. He harvested a deer in November of 2017. He hasn't hiked "as much" since his surgery. He hasn't done any camping since his surgery.

Petitioner acknowledged receiving pay increases since returning to work after his surgery.

On redirect examination Petitioner was asked what, if anything, had happened to his knee since he last saw Dr. Koth. He explained that the more he has to do, like ladder climbing, the more he experiences pain and when climbing down he "has to be careful." He does some things a little slower because he is the only one there in the plant and if something happens to him, there's no one available. In a nutshell, Petitioner's level of pain increases with his level of activity and since last seeing Dr. Koth, his level of activity has steadily increased.

Petitioner acknowledged that he is not claiming permanent partial disability for his right knee complaints.

Respondent did not have Petitioner examined by a physician of its choosing.

The Arbitrator concludes:

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) 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).

(i) Level of Impairment: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) Occupation: Petitioner continues to be employed by Respondent as a stationary fireman, a job requiring a great deal of physical activity and being on one's feet. He is the only one working in the plant during his shift. Petitioner credibly testified that he has difficulty ambulating for prolonged periods of time, climbing ladders, and inspecting and transferring water pumps low to the ground as a result of his injury. While Petitioner has returned to full duty work for Respondent and in his previous position, he does not perform his job in the same manner or as easily as he did prior to his work accident herein. He no longer kneels on his left knee and has trouble squatting and climbing with the left knee. As he increases his activity level he notices an increase in his pain and discomfort and, occasionally, swelling. The Arbitrator gives significant weight to this factor.

(iii) Age: Petitioner was 62 years old at the time of his injury. As such, he is considered an older member of the work force. He anticipates only working another three years before retiring. The Arbitrator gives some weight to this factor.

(iv) Earning Capacity: There is no evidence of reduced earning capacity in the record. Therefore, the Arbitrator gives no weight to this factor.

(v) Evidence of disability as corroborated by the treating medical records: As a result of his accidental injury, Petitioner sustained a significant injury to his left knee resulting in complex tearing that required surgical repair and removal of a loose body. Despite the improvement from care and treatment, he continues to experience soreness, stiffness, occasional swelling in his left knee. These concerns were noted in Dr. Koth's post-surgery recovery visits with Petitioner. While it is true Petitioner was doing great when last seen by Dr. Koth, he credibly testified that his level of activity has increased since that last visit and, in turn, he's had an increase in discomfort and complaints. He uses Tramadol prescribed by Dr. Rider to alleviate his symptoms. His hobby of working on his farm has been adversely affected by his injuries.

Petitioner was a very credible witness and his testimony was unrebutted. Respondent did not have Petitioner examined by a doctor of its choosing nor did it present any witnesses to refute Petitioner's testimony regarding how performing his job duties affects his knee. The Arbitrator finds Petitioner's testimony regarding ongoing problems and concerns to be generally corroborated by the medical records given the nature of the injury and the resulting surgery. His ongoing complaints are consistent with the nature of the treatment he received for his injury. While the physical therapy records weren't included in the record they were readily available to both sides. Similarly, while Petitioner testified that Dr. Rider refills his prescriptions for pain medication, no updated records from that office were submitted (they were current through the end of July 2017

– see PX 3); however, they, too, would have been available to both parties. Therefore, in this instance, and in light of Petitioner's overall credibility, no negative inference is drawn from their omission. The Arbitrator gives some weight to the last factor.

Based upon the foregoing, the Arbitrator finds that Petitioner has sustained serious and permanent injuries resulting in the 17.5% loss of use of his left leg.

****

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

Martin Cuevas,

Petitioner,

18IWCC0584

vs.

NO: 16 WC 30213

Nehring Electrical Works Co,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, causal connection, reasonable and necessary medical treatment, 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 September 27, 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.

18IWCC0584

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 $19,300.00. 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: SEP 25 2018
o9/20/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0584

CUEVAS, MARTIN
Employee/Petitioner

Case# **16WC030213**

NEHRING ELECTRICAL WORKS CO
Employer/Respondent

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:

2553 LAW OFFICE OF JAMES P McHARGUE
MATT JONES
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL R SIMONES
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

18IWCC0584

18IWCC0584

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)

MARTIN CUEVAS
Employee/Petitioner

v.

NEHRING ELECTRICAL WORKS CO
Employer/Respondent

Case # **16** WC **30213**

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, IL**, on **August 11, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **August 22, 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 **$44,634.72**; the average weekly wage was **$858.36**.

On the date of accident, Petitioner was **63** 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 **$16,431.46** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$16,431.46**.

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 $572.24/week for 48 and 1/7 weeks, from August 26, 2016 through February 20, 2017, and also March 7, 2017 through August 11, 2017, as provided in Section 8(b) of the Act. Respondent shall receive a credit for any TTD or other disability benefits it has paid thus far.

Respondent shall pay Petitioner's outstanding medical bills from RNS Physical therapy in the amount of $7971.82, and Midwest Neurosurgery in the amount of $100.00, pursuant to IWCC Fee Schedule or negotiated rate, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for lumbar surgery as recommended by Dr. Ross.

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

9/26/17
Date

SEP 27 2017

18IWCC0584

FINDINGS OF FACT

This claim involves a Petitioner alleging injuries sustained while working for the Respondent on August 22, 2016. Respondent disputes Petitioner's claims and the issues in dispute are as follows: 1) causation, 2) medical expenses, 3) TTD and 4) prospective medical care. This matter proceeded to hearing pursuant to Section 19(b) of the Act. Petitioner testified in Spanish via an interpreter.

Petitioner testified that he has been employed as a Machine Operator for Respondent for the past 28 years. His job consists of rolling up copper wire into steel spools. He would then have to push and pull the heavy spools to be able to ship them out. About three hours into his shift on August 22, 2016, while taking a spool down a ramp, the spool became stuck. While Petitioner was pulling at it to get it to move, he felt a popping sensation in his back, which then began to hurt. The pain was in middle back and lower back.

Petitioner testified that he suffered an earlier workplace accident, which is not at issue in this trial, on June 27, 2013. Petitioner was still working for Respondent at this time, and was changing parts in a smaller spool. A forklift hit the spools, which caused a door to bang into Petitioner's back. Petitioner had two dates of service with Physician's Immediate Care for this accident, and went back to work the next day, having only missed one day of work. (PX 1) Since that time, Petitioner has had follow-ups with his primary doctor, which at times addressed his back. (PX 5) Throughout the time between June 2013 and his workplace accident in August of 2016, Petitioner worked for Respondent at full capacity, without missing work due to his back. He continued to have a little bit of pain, but he was able to treat it with medication. Petitioner completed a course of physical therapy in November 2014 at Midwest Orthopaedic Institute and was discharged in January 2015 without any further recommendations for care regarding his back. (PX 6) Throughout this time Petitioner had a little low back pain, as well as occasional pain in his left leg. (PX 6) He felt the pain approximately two to three times a week, from June 2013 to August 2016, which Petitioner would treat with medication. At no time prior to August 2016 did any of his physicians discuss injection therapy or surgical intervention for Petitioner's lumbar spine. (PX 5, PX 6) Petitioner testified that following his workplace accident on August 22, 2016 the pain in his back was stronger, and he began to feel numbness in his left leg. He also testified that, following his accident in August 2016, he felt pain in his back every day.

Petitioner was sent to Physicians Immediate Care on August 23, 2016, where an MRI was ordered, and he was given Tylenol with codeine. (PX 1) He was given 40# work restrictions, and worked with these restrictions. (PX 1) A blood alcohol test was negative. The history at PIC indicates that on August 22, 2016, Petitioner was pulling a 300# reel which became stuck, and that when Petitioner pulled it, he felt low back pain with numbness and tingling in the left leg. (PX 1) Petitioner acknowledged that he had had some back pain since his 2013 injury. He returned to PIC on August 25, 2016, complaining of continuing back pain with left leg numbness and tingling. At this point, Petitioner's lumbar MRI had not yet been completed.

On August 26, 2016 Petitioner sought a second opinion from Dr. Gabriel Rivera at RNS Physical Therapy. (PX 2) Petitioner was taken off of work on August 26, 2016 by Dr. Rivera, and has not been back to work since that time, with the exception of two weeks: February 21, 2017 through March 6, 2017. During those two weeks Petitioner worked light duty, but was not able to tolerate standing for more than two hours. On August 26, 2016, Petitioner gave a consistent history to Dr. Rivera. On physical exam, Petitioner had a positive bilateral straight leg raise test. Physical therapy was

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recommended, and a new MRI referral was generated. Petitioner began physical therapy care, which continued until April 25, 2017.

Petitioner received his MRI from Fox Valley Imaging on September 8, 2016, which indicated disc herniations at multiple levels and an annular tear at the L4-5 level with moderate to severe stenosis, abutting the L4 and L5 nerve roots bilaterally. (PX 3) Based on the MRI findings, Dr. Rivera referred Petitioner to Dr. Novoseletsky, who he saw on September 15, 2016. Dr. Novoseletsky recommended a course of lumbar epidural steroid injections, the first of which was performed on October 19, 2016 at the L5-S1 level. At his first physical therapy appointment after the injection, Petitioner stated that his condition had improved. As of October 28, 2016 Petitioner stated his symptoms were returning. Dr. Novoseletsky noted on November 10, 2016 the injection had provided 50% relief for a few days, and then the pain returned. (PX 3) Dr. Novoseletsky performed a second injection on December 27, 2016, changing his target this time to L4-5 and L5-S1 on the left. On January 12, 2017, Petitioner indicated that he had experienced a temporary 70% resolution of symptoms, but that he was feeling the same as before the injection. Dr. Novoseletsky performed on February 7, 2017 a repeat of the same injection at L4-5 and L5-S1 left, which resulted in only a 40% resolution of symptoms for about a week. Dr. Novoseletsky then recommended consultation with Dr. Matthew Ross, a spine surgeon.

Petitioner saw Dr. Ross on March 21, 2017. (PX 4) Dr. Ross indicated that Petitioner was experiencing neurogenic claudication, or nerve root impingement, due to lumbar stenosis. He opined that while the stenosis was preexisting, the work injury of August 22, 2016 was the proximate cause for the current condition. Dr. Ross recommended L2-L5 bilateral hemilaminectomy, facetectomy, and foraminotomy. Petitioner consented to this course of treatment. As of the date of trial, Petitioner has not undergone this surgical procedure, but wishes to do so.

Prior to this injury, Petitioner testified he was able to stand the whole day at work. During the two weeks that Petitioner worked, February 21, 2017 through March 6, 2017, he was unable to complete the two block walk between his home and his workplace without several rest stops. Petitioner testified that the numbness he experienced in his leg had also become more frequent. He has continued physical therapy, presenting for checkups once a month. Petitioner reiterated that he has pain in his lower back, which is significantly more severe than his symptoms prior to his August 22, 2016 workplace accident. On cross-examination, Petitioner acknowledged that he had left leg tingling since 2014 that had gone away "somewhat but not completely" between 2014 and August 2016. He acknowledged that a lumbar CT had been performed in 2014. On redirect, Petitioner reiterated that he worked his full duty job from 2014 until August 2016. He does not feel that he can do so now, even with medication.

Dr. Andrew Zelby saw Petitioner on December 14, 2016 in a Section 12 examination requested by the Respondent. Dr. Zelby reviewed multiple x-rays. He reviewed the 2016 MRI report, but did not review the actual films. He opined that "if there were (MRI) evidence for an acute abnormality, it is possible that Mr. Cuevas accelerated his already symptomatic condition beyond its normal progression." (RX 1) However, if there was "no evidence for any acute abnormalities…his reported work injury in August 2016 would be a temporary exacerbation of a pre-existing and already symptomatic condition that was not accelerated beyond its normal progression." On April 3, 2017, Dr. Zelby reviewed the 2016 MRI films. Rx2. He did not review the 2014 lumbar CT scan. He opined that there were no acute or post-traumatic abnormalities, such that there was no aggravation, exacerbation, or acceleration of Petitioner's condition as a result of the August 2016 accident. He opined that after 6-8 weeks of physical therapy and 2-3 lumbar epidural injections, Petitioner would be able to return to work.

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Dr. Ross commented on this in his April 17, 2017 report, stating that he agreed with Dr. Zelby that Petitioner had symptomatic stenosis prior to the August work accident. (PX 4) However, Dr. Ross believed that there was a progression of stenosis beyond normal progression, based on the substantial worsening of Petitioner's condition after the August accident.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding the Arbitrator relies on the Petitioner's credible testimony and the preponderance of the medical evidence. The underlying question on this issue is whether the Petitioner's current condition of ill-being is simply a continuation of the symptoms from his prior injury from 2013, or whether the August 22, 2016 accident was a permanent aggravation or exacerbation of his prior. condition. The evidence indicates the latter situation in this case. While the evidence shows that the Petitioner continued to receive medical treatment following his prior June, 2013 accident for continued complaints of pain, he was able to continue working his heavy job with no restrictions and was able to manage his pain through medication during the three years prior to the accident at issue. Petitioner credibly testified that he did have complaints of back pain prior to August 22, 2016, but the pain was much stronger and more consistent following the August 22, 2016 event. His testimony of attempting to return to work for two weeks and his inability to continue doing so because of the pain from standing for long periods of time as required by his job was both credible and indicative of a significant worsening of his back condition. Although the Arbitrator notes Dr. Zelby's opinions of a temporary aggravation of a Petitioner's pre-existing condition and the lack of any acute changes between Petitioner's MRI findings both before and after the accident in question, Dr. Zelby does not address Petitioner's functional changes, the orthopedic findings or the CT scan results in his assessment. On the contrary, the evidence shows Petitioner had a preexisting stable condition of lumbar stenosis that was permanently exacerbated and accelerated by the work accident of August 22, 2016. Since the August 22, 2016 accident, Petitioner has not returned to his pre-accident baseline of functional low back pain, managed by ibuprofen. The Arbitrator finds persuasive the opinions of Dr. Ross who indicated that the natural progression of Petitioner's disease would not cause him to suddenly become unable to work on August 22, 2016. Accordingly, the Arbitrator concludes that the Petitioner's current condition of ill-being is causally connected to his August 22, 2016 work accident.

2. Regarding the issue of medical expenses, consistent with the Arbitrator's conclusions on the issue of causation, the Arbitrator finds that the Petitioner's medical treatment for his back condition has been reasonable and necessary to address his work-related back condition. Petitioner claimed $7,971.82 in outstanding physical therapy bills at RNS Physical Therapy, as well as $100.00 for the April 17, 2017 appointment with Dr. Matthew Ross. Having found causal connection in favor of the Petitioner, the Arbitrator awards Petitioner these medical expenses and Respondent shall pay the same subject to the Fee Schedule.

3. With regard to the issue of prospective medical care, the Arbitrator finds that the proposed surgical care recommended by Dr. Ross is reasonable and necessary to address Petitioner's work-related back condition. This finding is in accordance with the Arbitrator's conclusions on the issues of causation and medical expenses. Therefore Respondent is ordered to authorize and pay for said procedure.

4. Regarding the issue of TTD, the Arbitrator finds that the Petitioner is entitled to TTD from August 26, 2016 through February 20, 2017, and also March 7, 2017 through the date of trial. In support of this

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finding the Arbitrator again relies on the Petitioner's credible testimony and the medical evidence. The Arbitrator notes that Dr. Rivera took Petitioner off work completely on August 26, 2016. Petitioner did attempt to return to work light duty for Respondent from February 21, 2017 through March 6, 2017, but could not continue thereafter due to his complaints of pain. Petitioner has been unable to return to work from March 7, 2017 through the date of trial. Therefore Respondent shall pay Petitioner TTD for said period of time and shall receive a credit for any TTD or disability benefits it has already paid thus far.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Harden,

Petitioner,

18IWCC0585

vs.

NO: 17 WC 2660

Navistar,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, prospective medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 18, 2018, 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.

18IWCC0585

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: SEP 25 2018
o9/20/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
8(A)

18IWCC0585

HARDEN, CHARLES
Employee/Petitioner

Case# **17WC002660**

NAVISTAR
Employer/Respondent

On 1/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% 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:

2333 WOODRUFF JOHNSON & EVANS
DEXTER J EVANS
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL UGASTE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

18IWCC0585

18IWCC0585

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
8(A)

CHARLES HARDEN
Employee/Petitioner

v.

NAVISTAR
Employer/Respondent

Case # 17 WC 2660

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **December 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Prospective Medical Treatment**

FINDINGS

On the date of accident, **January 12, 2017**, 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 **$58,415.76**; the average weekly wage was **$1,123.38**.

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

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

Respondent is entitled to a credit of **$370.81** under Section 8(j) of the Act.

ORDER

- Respondent shall authorize and pay for the surgery recommended by Sostak and its attendant care pursuant to Sections 8 and 8.2 of the Act.
- Respondent shall pay the medical bills contained in Petitioner's Exhibit No. 7 pursuant to Sections 8 and 8.2 of the Act. To the extent these medical bills have been paid by Petitioner's group insurance, Respondent is entitled to an 8(j) credit for any such payments and shall hold Petitioner harmless for same.

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.

Carolyn M. Doherty

Signature of Arbitrator

1/17/18

Date

ICArbDec19(b)

JAN 18 2018

FINDINGS OF FACT

At trial, the parties stipulated that on 1/12/17, the 47 year old Petitioner sustained a work related accident when he slipped on ice in a parking lot at work. ARB EX 1. Specifically, Petitioner testified that worked over 20 years for Respondent picking truck parts using a forklift to pull the part and place on a pallet. Petitioner testified that the truck parts could weigh up to 200 pounds.

Petitioner testified that on the date of accident he was at work when he slipped on ice in the parking lot and braced his fall with his arms out straight. He testified that a co worker helped him up and that he punched in to work and attended the start up meeting. Petitioner testified that after a while he began to notice pain in his right shoulder and informed his supervisor that he fell in the parking lot. Petitioner testified that prior to the accident he had no problems with or treatment to his right shoulder.

Petitioner was sent by Respondent to Physicians Immediate Care on the date of accident. Petitioner was given a sling and sent back to work. Petitioner testified that he worked for 6 hours using a feather duster with his left arm.

Petitioner testified that he next sought treatment from an orthopedic Dr. Lieber at DuPage Medical Group on 1/16/17 where he was given medication and sent to physical therapy for 6 to 8 weeks under the diagnosis of a right shoulder sprain. PX 3. Petitioner previously treated at DuPage Medical for his bilateral knee replacements in 2013. PX 3. Petitioner testified that PT did not help his condition and that the symptoms worsened. After 4 PT visits, the physical therapist noted on 2/1/17 that Petitioner "reports no change in pain symptoms, anxious to get an MRI to rule out possible tear, joint pathology. Petitioner was advised to continue PT and exercise at home but was noted to insist that imaging and further testing should be done. On 2/2/17, Dr. Lieber ordered a right shoulder MRI. Petitioner was kept on work restrictions during this period which were accommodated by Respondent. TTD is not at issue. ARB EX 1.

The right shoulder MRI was done on 2/8/17 and showed "severe glenohumeral osteoarthritis ... no evidence of acute fracture or dislocation; associated diffuse maceration and degenerative tearing of the labrum; moderate to severe acromioclavicular osteoarthritis; moderate glenohumeral joint effusion with synovitis and debris; moderate grade intrasubstance partial tearing at supraspinatus insertion no full thickness rotator cuff tear or muscle atrophy." PX 4. The findings also revealed intact biceps tendon, no Hill-Sachs deformity and severe, marked glenohumeral osteoarthritis with diffuse high grade chondromalacia. PX 4.

Petitioner testified that he did not return to Dr. Lieber or DuPage Medical because he did not like Dr. Lieber. Rather, at his wife's suggestion, Petitioner sought treatment at Fox Valley Orthopedic. Petitioner first saw Dr. Petsche at Fox Valley on 2/10/17. Dr. Petsche advised that Petitioner may need a shoulder replacement so Petitioner was sent to see Dr. Sostak at Fox Valley as he performed shoulder replacement surgery. Petitioner first saw Dr. Sostak on 2/15/17 and denied prior shoulder pain. Petitioner reported falling on ice at work and developing right shoulder pain thereafter. PX 1, p. 11. Dr. Sostak reviewed the prior x-rays and MRI and testified that these tests revealed "extensive glenohumeral degenerative joint disease...some partial tearing of the rotator cuff, but the most significant issue was the arthritis." PX 1, p. 12. No evidence of acute fracture or dislocation was seen. Dr. Sostak diagnosed right shoulder osteoarthritis and offered treatment options including injection, PT or right shoulder replacement surgery. Petitioner chose to have the surgery. PX 1, p. 15. Petitioner had one injection on 4/10/17 and then at the visit of 4/20/17 reported no improvement with continued pain and functional impairment. Dr. Sostak noted that based upon the failure of conservative care, Petitioner could either live with his pain or have the replacement surgery. PX 1, p. 16. Petitioner was given restrictions of

no lifting over 10 pounds and no work involving the right arm. PX 1, p. 17. Dr. Sostak opined that the work accident "aggravated an underlying chronic condition" in Petitioner's right shoulder based on Petitioner's report of no prior symptoms in the right shoulder and that the aggravation ultimately led to the surgical recommendation. PX 1, p. 18-19

On cross, Dr. Sostak was asked, "...Can you point to anything specifically within the shoulder... anatomy itself...that was actually injured or that shows signs of a fresh trauma within the shoulder as a result of the accident doctor?" Dr. Sostak responded, "So I can't say specifically... so there is some inflammation in the rotator cuff, all of which could have happened with trauma, but there was no evidence for fracture. So my statement would be that I can't say with any 100 percent certainty that the findings on the MRI were directly from the fall, but some of the inflammation that was in the shoulder into the rotator cuff could have been caused by that." He agreed that inflammation in the rotator cuff is typically diagnosed as a strain-type injury and that the treatment for inflammation of the rotator cuff is never joint replacement. PX 1, p. 25. He further agreed that the osteoarthritis pre dated this accident and that without the osteoarthritis of the shoulder there is no need to perform a joint replacement. PX 1, p. 26. Dr. Sostak believes that the condition caused by the fall was a permanent aggravation of the underlying condition as Petitioner has continued to experience symptoms after the fall which have not subsided. PX 1, p. 27. Lastly, Dr. Sostak testified that it is possible that rotator cuff inflammation and aggravation of osteoarthritis are each causing the current symptoms. PX 1, p. 28.

Petitioner also attended a Section 12 exam with Dr. Alpert at Respondent's request in March 2017. RX 1. Dr. Alpert reviewed Petitioner's February MRI films and report. He determined that Petitioner had "advanced arthritis of his glenohumeral joint, which is the ball and socket joint, as well as his AC joint, which is the joint between his clavicle and the shoulder blade." When asked why he did not reference degenerative tearing of the labrum and supraspinatus insertion noted by the radiologist, Dr. Alpert stated, "because every patient who has severe arthritis of their shoulder at the ball and socket area have labral tears. When the ball and socket rub the labrum tears, so that is something of a degenerative condition. Somebody with his x-ray and MRI findings with end stage arthritis in the shoulder and AC joint arthritis also commonly will have partial thickness rotator cuff tearing. Those are all degenerative conditions. So I didn't dictate every single line of the MRI findings, I just dictated what I thought was the most important at that time, which is the arthritis of his shoulder." RX 1, p. 15. His diagnosis was a 48 year old male with bone on bone osteoarthritis who had a fall at work and exacerbated his previously asymptomatic right shoulder end stage osteoarthritis. He determined the diagnosis was causally related to the work accident. RX 1, p. 16. He opined that Petitioner could benefit from a cortisone injection to take away the inflammation from the acute exacerbation of his shoulder strain and the osteoarthritis exacerbation.

Although Dr. Alpert agreed that Petitioner will need a shoulder replacement in the future due to his advanced arthritis, he does not believe the need for replacement is related to the accident stating, "he had degenerative arthritis in his shoulder, it was advanced, it was end stage in the ball and socket and in the AC Joint. Those are degenerative conditions from wear and tear over time and not from an injury where you fall out in the way that he did. That certainly did not cause his end stage degenerative arthritis of his shoulder." RX 1, p. 18. Again he thought one injection would be reasonable treatment to reduce the inflammation which he did attribute to the accident. RX 1, p. 19.

On cross, Dr. Alpert clarified his opinion that the accident aggravated Petitioner's previously asymptomatic end stage arthritis. RX 1, p. 21. He stated that he has treated many patients with arthritis who strain the arthritis causing inflammation which goes down after cortisone injection and the patient returns to pre-existing asymptomatic levels. RX 1, p. 21. Dr. Alpert testified several times that the need for shoulder replacement

surgery was due solely to Petitioner's pre-existing arthritic condition and not to the temporary aggravation of that condition suffered as a result of the accident. RX 1, p. 22-35. Without some sort of traumatic damage to the cartilage shown on the MRI, Dr. Alpert would not find the shoulder replacement related to the work injury nor did he agree the accident accelerated the need for surgery. RX 1, p. 35-36.

At trial, Petitioner testified that his shoulder symptoms are worsening and the surgery has not been authorized. Petitioner described shoulder pain and muscle spasm along with the inability to perform everyday tasks. Petitioner agreed that he can lift things at work without a forklift but that he no longer rides a motorcycle or bowls due to the accident. Petitioner testified that he continues to lift weights which he has done since high school.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, and "K" and "O," whether Respondent is responsible for Petitioner's prospective medical treatment, the Arbitrator makes the following conclusions:

It is well established that an accident need not be the sole or primary cause but rather a cause of Petitioner's condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC. Furthermore, an employer takes its employees as it finds them. *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC. A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982).

The Arbitrator initially notes that accident is not in dispute. The question is whether the accident aggravated a preexisting condition and resulted in the need for the requested surgery. The severity of Petitioner's pre-existing degenerative right shoulder arthritis is not lost on the Arbitrator. However, it is equally clear from the record that Petitioner's pre-existing arthritis was completely asymptomatic prior to the accident without contrary evidence in the record. Furthermore, Petitioner worked without right shoulder problem until the day he slipped on the ice and fell on outstretched arms at work. Only thereafter did Petitioner notice pain and symptoms in his right shoulder for which he treated immediately and conservatively. After conservative care (injection and PT) failed to relieve his symptoms, his treating physician ordered the replacement surgery.

The Arbitrator finds it clear from the record in this case that the work accident aggravated Petitioner's pre-existing arthritic condition, causing it to become more than temporarily symptomatic. The symptoms did not subside after injection and physical therapy. Petitioner's treating physician opined that the shoulder replacement surgery became necessary as a result of the fall at work which aggravated the condition of arthritis. In making these findings of causal connection, the Arbitrator places greater weight on the opinion of treating doctor, Dr. Sostak, as buttressed by the chain of events and Petitioner's credible testimony. Accordingly, the Arbitrator finds causal connection between the undisputed work accident, Petitioner's current condition if ill-being in his right shoulder and the need for replacement surgery as prescribed by Dr. Sostak. The Arbitrator finds that Respondent shall authorize and pay for the prescribed right shoulder replacement surgery and its attendant costs pursuant to Sections 8 and 8.2 of the Act.

In support of the Arbitrator's decision relating to "J," whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent paid all appropriate reasonable and necessary medical costs, the Arbitrator makes the following conclusions:

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in connection with the care and treatment of his causally related injuries pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for all amounts paid, including amounts paid for which credit under Section 8(j) of the Act is allowed. Respondent shall hold Petitioner harmless for same.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTONIO LOPEZ,

Petitioner,

vs. NO: 11 WC 40496

BLOOMINGTON JANITORIAL SERVICES,

Respondent.

18IWCC0586

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent, medical expenses, and maintenance benefits, 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 parties stipulated as to accident and causal connection. The only issues at Arbitration were maintenance, nature and extent, medical expenses and vocational rehabilitation. The Arbitrator, on a §19(b) Motion, wrote his decision awarding medical expenses, maintenance and vocational rehabilitation. In their cross-petitions for review, the parties stipulated to and requested their review on the nature and extent of Petitioner's injuries. The Commission therefore vacates the award for vocational rehabilitation, and instead finds that Petitioner sustained the 50% loss of person as a whole.

Respondent began paying maintenance benefits on August 7, 2013. Petitioner was sent for a vocational rehabilitation program with Corvel on January 29, 2014. A Corvel associate conducted a labor market survey on March 18, 2014. They concluded that with a diligent job search, Petitioner could obtain employment in several different occupational fields. Petitioner began a vocational placement program on May 14, 2014. However, by December 12, 2014, the Corvel case manager concluded that Petitioner was not participating in a diligent and pro-active

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job search. Their final report of February 6, 2015, concluded that Petitioner did not consistently complete vocational placement assignments, including weekly contacting potential employers, documenting contacts with potential employers, attending meetings and communicating via email with his case manager, or checking his own email account. Petitioner was also evaluated by vocational consultant, Bob Hammond, who concluded in his April 8, 2015 report that there was a stable labor market for Petitioner if Petitioner were to conduct a diligent job search. Petitioner's own vocational consultant, James Ragains, also concluded that Petitioner was not fully cooperative or fully diligent in pursuing employment for the same reasons expressed by the Corvel case manager. Ultimately, Mr. Ragains testified that Petitioner was not really motivated to find a job in Illinois because he didn't want to stay in Illinois. This sentiment was echoed by Bob Hammond who testified that Petitioner wanted to go back to California to be with his wife. As Petitioner did not put forth a good faith effort to obtain employment and comply with vocational rehabilitation, maintenance benefits were appropriately terminated.

Further, Petitioner did not establish permanent total disability. Petitioner cannot sabotage his own job search and then claim there is no stable job market. Petitioner failed to cooperate with the vocational rehabilitation program and failed to put forth a good faith effort to find employment. The Commission, therefore, makes a permanent partial disability determination.

The Commission finds that based on Petitioner's age and language barriers, this case is ripe to award permanency benefits, rather than additional vocational rehabilitation. Petitioner's accident took place post-September 1, 2011, so the Commission performed the following §8.1(b) analysis:

(i) No impairment rating was performed, so the Commission gave this factor no weight.
(ii) Petitioner worked as a janitor. The Commission gave this factor some weight.
(iii) Petitioner was 55 years old at the time of the accident, and is currently 62 years old. The Commission gave this factor greater weight.
(iv) Petitioner has a 6th grade Mexican education from 40 plus years ago, and has on-going physical restrictions. Additionally, Petitioner has significant language limitations, and never obtained a high school diploma or GED. The Commission gave this factor greater weight.
(v) Petitioner, although at MMI, has continued work restrictions and significant physical limitations. The Commission gave this factor greater weight.

Based on the above analysis, the Commission determined Petitioner has suffered a 50% loss of use of person as a whole.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay maintenance benefits to Petitioner of $319.00 per week for a period of 88 1/7 weeks, commencing August 7, 2013, through April 14, 2015, under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.00 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 50% loss of the person as a whole.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses, as identified in Petitioner's Exhibit 10 as provided in §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

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

DATED: SEP 27 2018

Charles J. DeVriendt

Joshua D. Luskin

CJD/dmm
O: 073118
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DISSENT

I respectfully dissent. I would affirm and adopt the decision of the arbitrator awarding further vocational rehabilitation services.

Petitioner suffered an accident on September 29, 2011 injuring his right hip resulting in permanent restrictions which precluded him from returning to work for Respondent. Respondent employed CorVel which commenced vocational services on January 29, 2014.

Several different counselors from CorVel worked with Petitioner through February 6, 2015. During the approximate year period, CorVel representatives met with Petitioner on numerous occasions. The initial interview was conducted on January 29, 2014 at which time the vocational counselor noted Petitioner was cooperative. Thereafter, no contact was made with Petitioner for approximately four months until May 14, 2014 at which time formal vocational services commenced. No testing was undertaken, but computer training was recommended. Petitioner advised he did not own a computer and did not have an e-mail account. The case manager helped Petitioner obtain an e-mail account and explained public computer access at the library. Thereafter, job leads were forwarded to Petitioner who also enrolled in a computer training class.

Petitioner continued with vocational placement but experienced difficulty in using a computer. Petitioner missed several appointments with the vocational counselor. Petitioner applied to jobs sporadically but had difficulty with following up with potential employers after submitting applications and failed to submit some applications. Petitioner continued to attend

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computer training. CorVel suspended vocational services on February 6, 2015 "as requested by customer due to Mr. Lopez not complying with weekly job search efforts." PX7.

Thereafter, Petitioner met with Mr. Bob Hammond of Hammond Vocational Services on April 8, 2015 at Respondent's request. Previously, Mr. Hammond performed a labor market survey on October 24, 2013 at Respondent's request identifying numerous jobs with a pay range of $8.35 to $11.00 per hour. After the April 8, 2015 meeting with Petitioner, Mr. Hammond authored a report that same day recommending Petitioner utilize the skills he developed while working with CorVel counselors concentrating on electronics positions and emphasizing Petitioner's need to be diligent in his job search efforts.

On September 9, 2015, Mr. Hammond provided testimony via evidence deposition. Mr. Hammond testified a stable labor market exists for Petitioner, and if Petitioner actively seeks employment, a job would be available. RX2, p.25. Mr. Hammond testified he would focus job placement efforts on the electronics field. When questioned as to Petitioner's likelihood to obtain employment in the electronics field, Mr. Hammond testified as follows: "I talked with him about that. I talked with him about why isn't he looking at electronics jobs here in Illinois. Because I couldn't find any. I couldn't even find CorVel identifying electronics jobs. He's got 20 years experience in electronics." RX2, p. 27. Mr. Hammond testified Petitioner advised he wished to return to California and would be able to obtain a job in electronics. RX2, p. 20-21. When questioned regarding Petitioner's failed vocational efforts with CorVel, Mr. Hammond thought CorVel bore 50% responsibility along with Petitioner. RX2, p. 61-62. Mr. Hammond testified many job leads identified by CorVel fell outside Petitioner's restrictions, and CorVel did not perform testing which he would likely perform. RX2, p. 69.

At Petitioner's attorney's request, Petitioner met with Mr. James Ragains, a certified rehabilitation counselor, who prepared a report on October 28, 2015. Mr. Ragains found Petitioner did not possess any transferable skills, and a stable labor market did not exist. Mr. Ragains based his opinion, in part, on Petitioner's prior work history which he understood to be volunteer work at a church in California operating a sound system and television repair.

On July 6, 2016, Mr. Ragains provided testimony via evidence deposition. Mr. Ragains testified Petitioner was not employable based upon his age, limited education, academic skills, and physical restrictions. PX9, p. 25-26. Mr. Ragains testified Petitioner's job placement assistance failed but conceded Petitioner was not fully cooperative or diligent. PX9, p. 27. Mr. Ragains testified vocational rehabilitation should not be undertaken as Petitioner is not employable. PX9, p. 37-38. Mr. Ragains testified he considered the work Petitioner performed at the church in arriving at his opinion. PX9, p.57.

Petitioner testified at trial he arrived in California in 1980 after which time he worked in electronics specifically maintenance of radios and electronic equipment, and he continued to perform such jobs until his relocation to Illinois in 2011. T. 43-47. Petitioner testified a job was currently available to him in California in the electronics field, but it is located too far from where he presently resides in California. T. 59-60. Petitioner testified if vocational rehabilitation services were offered in Illinois, he would cooperate and if a job found, he would accept. T. 40-41.

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Petitioner is entitled to ongoing vocational rehabilitation services and maintenance benefits assuming his ongoing cooperation. Both Mr. Hammond, the Respondent's expert, and Mr. Ragains, the Petitioner's expert, agree the vocational services provided by CorVel were inadequate. Both experts also agree Petitioner's diligence was not exemplary, but without the appropriate services being provided, it is difficult to label Petitioner's submaximal efforts as a failure to cooperate as it appears the majority is doing.

Where the experts diverge is the necessity of ongoing vocational services. Mr. Hammond testified a stable labor market exists, and if given the appropriate job placement assistance, employment could be obtained by Petitioner. In contrast, Mr. Ragains testified Petitioner was not employable as no stable labor market exists. Mr. Ragains' opinion, though, is flawed as he possessed an inaccurate understanding regarding Petitioner's transferable skills in the electronics field. Petitioner testified at trial of a long employment history in the electronics field. Petitioner testified a job was, in fact, available to him in the electronics field in California but was too far of a commute from his residence in California. Mr. Ragains simply did not have an accurate understanding of Petitioner's prior job history and skills. An expert's opinion is only as good as the facts upon which it is based. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC. I would afford greater weight to the opinions of Mr. Hammond as the arbitrator implicitly did in his opinion and award further vocational rehabilitation services with maintenance benefits assuming the cooperation of Petitioner. Accordingly, I dissent.

L. Elizabeth Coppoletti

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

LOPEZ, ANTONIO
Employee/Petitioner

Case# **11WC040496**

BLOOMINGTON JANITORIAL SERVICE
Employer/Respondent

18IWCC0586

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:

5847 THE LAW OFFICE OF DAVID HUNT
245 N E PERRY AVE
PEORIA, IL 61603

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

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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)

Antonio Lopez
Employee/Petitioner

Case # 11 WC 40496

v.

Consolidated cases: n/a

Bloomington Janitorial Services
Employer/Respondent

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, September 29, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $18,202.60; the average weekly wage was $350.05.

On the date of accident, Petitioner was 55 years of age, single with 2 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 $27,742.00 for TTD, $0.00 for TPD, $30,152.57 for maintenance, and $0.00 for other benefits, for a total credit of $57,894.57. The parties stipulated that TTD benefits were paid in full.

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

ORDER

Respondent shall pay reasonable and necessary medical expenses, as identified in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner maintenance benefits of $319.00 per week for 178 4/7 weeks commencing August 7, 2013, through January 13, 2017, as provided in Section 8(a) of the Act.

Respondent shall authorize and pay for vocational rehabilitation services for Petitioner with a vocational rehabilitation expert who has not previously provided services to/evaluated Petitioner, 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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

February 7, 2017
Date

FEB 14 2017

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which both alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on September 29, 2011. The case numbers were 11 WC 40059 and 11 WC 40496. The cases were previously consolidated; however, because they were both filed in regard to the same date of accident, counsel for Petitioner and Respondent agreed that the Arbitrator would enter an Order voluntarily dismissing case number 11 WC 40059. Accordingly, the Arbitrator dismissed case number 11 WC 40059.

The Application filed in case number 11 WC 40496 alleged that on September 29, 2011, Petitioner fell on a wet floor and sustained an injury to the man as a whole (Arbitrator's Exhibit 2). There was no dispute that Petitioner sustained a work-related injury and his present condition of ill-being was causally related to same. Respondent disputed liability for various medical bills tendered into evidence by Petitioner; however, at trial, Respondent did not tender any evidence in support of that position. In regard to temporary total disability benefits, Petitioner alleged he was entitled to temporary total disability benefits of 97 weeks, commencing September 30, 2011, through August 6, 2013. Respondent stipulated Petitioner was entitled to said temporary total disability benefits. Petitioner also claimed he was entitled to maintenance benefits of 178 4/7 weeks, August 7, 2013, through January 13, 2017 (the date of trial). Respondent disputed liability for the period of maintenance claimed by Petitioner and Respondent's position was that Petitioner was entitled to maintenance benefits of 105 3/7 weeks, August 7, 2013, through April 14, 2015 (Arbitrator's Exhibit 1).

The primary dispute in regard to Petitioner's entitlement to continued payment of maintenance benefits was whether he was cooperative with efforts to provide him with vocational rehabilitation services. Counsel for Petitioner took the position that Petitioner was permanently and totally disabled as an odd lot permanent and total disability. Counsel for Respondent took the position that Petitioner was not permanently and totally disabled, but was entitled to an award of permanent partial disability.

Petitioner worked for Respondent as a janitor. On September 29, 2011, Petitioner sustained a slip and fall and injured his right hip. Subsequent to the accident, Petitioner was taken to Pekin Hospital. X-rays were taken which revealed transverse fractures through the neck of the right femur. Petitioner was then referred to Dr. Tracey De Lucia, an orthopedic surgeon (Petitioner's Exhibit 1).

Dr. De Lucia performed surgery on September 29, 2011, and the procedure consisted of closed reduction and pinning of the fractures of the right femur. Following surgery, Petitioner continued to have significant pain/tenderness in the right hip and Dr. De Lucia referred Petitioner to the Center for Pain Management (Petitioner's Exhibits 3 and 4).

Dr. De Lucia subsequently opined that the metal hardware was the cause of Petitioner's symptoms. On October 29, 2012, Dr. De Lucia performed surgery which consisted of removal of the metal hardware (Petitioner's Exhibit 3).

Dr. De Lucia continued to treat Petitioner following the second surgery. On August 6, 2013, Dr. De Lucia discharged Petitioner from care and imposed permanent restrictions of no heavy lifting greater than 20 pounds from ground level and no walking for than 30 minutes on a continuous basis. She also opined Petitioner might need a cane (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Keith Komnick, an orthopedic surgeon, on September 10, 2013. In connection with his evaluation of Petitioner, Dr. Komnick reviewed medical records provided to him by Respondent. On examination, Dr. Komnick noted a deficiency of internal rotation of the right hip when compared to the left and Petitioner was apprehensive when his right hip was flexed to 90°. Dr. Komnick opined Petitioner was at MMI and had been so for approximately six to eight weeks. Dr. Komnick stated that Petitioner's symptoms and examination findings were consistent with arthritic disease of the right hip. Dr. Komnick opined Petitioner had restrictions of lifting of amounts less than 20 to 30 pounds, no walking/standing for more than 30 continuous minutes and no repetitive bending/lifting activities (Petitioner's Exhibit 6).

At trial, Petitioner testified in English; however, there were times in which it was difficult for the Arbitrator to understand him. Petitioner stated he was born in Mexico and lived there until he moved to the United States in 1980. While living in Mexico, Petitioner attended school through the sixth grade. Afterward, Petitioner worked on a farm until he moved to the United States in 1980.

Upon moving to the United States, Petitioner lived in California for a significant period of time. Petitioner stated he did not have either a high school diploma or GED; however, Petitioner attended two classes at a community college in basic electronics. While residing in California, Petitioner worked doing electronic repairs on VCRs, stereos, car radios, etc.

At the direction of Respondent, Petitioner met with a vocational rehabilitation counselor with Corvel (Petitioner dealt with several employees of Corvel, so the Arbitrator will refer to those dealings as with Corvel) on January 29, 2014. At that time, Petitioner advised he could conduct the initial interview in English, but he was most comfortable in Spanish. Accordingly, the interview was conducted in Spanish (Petitioner's Exhibit 7).

Corvel provided vocational services to Petitioner from January 29, 2014, through February 6, 2015. During that time, Petitioner was not tested to determine what cognitive level he functioned at and no recommendation was made that Petitioner attempt to obtain a GED. The only formal training Petitioner participated in during that period of time was a computer course and a typing course (Petitioner's Exhibit 7). At trial, Petitioner testified his computer and typing skills were limited.

Corvel attempted to find employment for Respondent. However, in the labor market survey dated March 18, 2014, which contained 24 potential jobs, seven of the jobs required a high school diploma/GED or bachelor degree. Other jobs contained in the survey required computer/typing skills while others had physical demands clearly inconsistent with Petitioner's work restrictions. During the Summer/Fall, 2014, it was noted Petitioner had not been compliant, failed to respond to emails and did not apply for jobs. On February 6, 2015, Corvel closed its

case file on Petitioner on the basis Petitioner had not been compliant with job search efforts (Petitioner's Exhibit 7).

At Respondent's request, Bob Hammond, a Certified Vocational Counselor, reviewed various records provided to him by Respondent and prepared a report dated October 24, 2013. Hammond did not meet with Petitioner at that time. In the report, Hammond opined Petitioner was employable in the local labor market taking into consideration Petitioner's restrictions and past work (Respondent's Exhibit 2; Deposition Exhibit 2).

Subsequent to Corvel's termination of vocational services, Hammond met with Petitioner on April 8, 2015. In regard to Petitioner's past work experience, he noted Petitioner had 20 years experience in electronics and could obtain a job in that field in California. Hammond opined Petitioner was employable in the greater Peoria area in a variety of jobs consistent with his restrictions and abilities. He opined Petitioner could make approximately $9.00 an hour (Respondent's Exhibit 1; Deposition Exhibit 2).

At the direction of his counsel, Petitioner was evaluated by James Ragains, a Certified Rehabilitation Counselor, on September 9, 2015. In connection with his evaluation of Petitioner, Ragains reviewed medical records and reports/records of Respondent's vocational experts. Ragains administered tests to Petitioner to measure Petitioner's skills in reading, spelling, sentence comprehension and math. Ragains also performed a transferable skills analysis (Petitioner's Exhibit 9; Deposition Exhibit 2).

In regard to the testing, Ragains noted that all of Petitioner's scores were below average. Petitioner's grade equivalent scores ranged from 2.2 in sentence comprehension to 4.3 in math computation. In regard to Petitioner's transferable skills, Ragains opined Petitioner had skills that would not enable him to return to work in his immediate job market. Ragains included Petitioner's prior work in repairing/servicing audio and video devices when he rendered that opinion. Ragains was critical of the vocational experts that previously evaluated Petitioner. He noted that Petitioner was not previously tested, the transferable skills analysis lacked a description as to how it was conducted and the labor market survey was inaccurate. Further, Ragains also noted that many of the job leads given to Petitioner were inappropriate because they required a high school diploma/GED or had physical demands beyond Petitioner's work restrictions. Finally, Ragains opined that given Petitioner's age, limited education, level of academic skills and lack of transferable skills, vocational rehabilitation/retraining was not appropriate (Petitioner's Exhibit 9; Deposition Exhibit 2).

Ragains was deposed on July 6, 2016, and his deposition testimony was received into evidence at trial. Ragains' testimony was consistent with his narrative report and he reaffirmed the opinions contained therein. Ragains testified that based upon the transferable skills analysis, testing, work history, education and his review of the medical records, Petitioner was not employable. At best, Petitioner was limited to unskilled work at a lighter sedentary level with a sit/stand option. He further opined Petitioner was not a candidate for vocational rehabilitation (Petitioner's Exhibit 9; pp 25-27).

Ragains agreed Petitioner was not fully cooperative with the job placement assistance previously provided to him; however, this did not cause him to change his opinion about Petitioner not being employable. He specifically noted that Petitioner was not given any tests and the prior labor market survey contained many jobs that required a high school diploma/GED and it did not provide an accurate statement that there was a stable job market for employment for which Petitioner was qualified. He stated the prior vocational experts were "...setting him up to fail." (Petitioner's Exhibit 9; pp 28-33).

Bob Hammond was deposed on September 9, 2016, and his deposition testimony was received into evidence at trial. Hammond's testimony was consistent with his narrative reports and he reaffirmed the opinions contained therein. Hammond testified Petitioner was not compliant with the vocational services that were previously provided to him because he did not perform the job search activities on a regular basis, did not maintain contact with the vocational specialist and was not applying for jobs. He also noted Petitioner's prior work experience of 20 years in electronics and Petitioner had informed him that if he returned to California, he could obtain a job in that area. He also stated that Petitioner had informed him he wanted to return to California and opined that this may have been a motivation which caused a hindrance to his obtaining employment. Hammond opined Petitioner was, in fact, employable in a variety of unskilled or semi-skilled positions (Respondent's Exhibit 2; pp 16-17, 20-21, 24-27).

On cross-examination, Hammond agreed that many of the job leads provided to Petitioner were jobs Petitioner was not qualified for or were beyond his work restrictions. In regard to the job leads provided to Petitioner and his lack of qualifications for same, Hammond stated "I'm not sure you're setting them up for failure, but I think you're doing a disservice to the client." He also agreed that given the fact that Petitioner was provided with inappropriate job leads, it could cause Petitioner's motivation to find a job to go down (Respondent's Exhibit 2; pp 54, 60-61).

At the time this case was tried, Petitioner was living in California and had to travel to Peoria for the hearing. Petitioner's wife resides in California with their younger son who is in school. Petitioner testified he could return to work for the company that previously employed him when he worked in electronics; however, that particular employer is 125 miles away from his home in California. Petitioner did state that if he could obtain work in Illinois, he would move here and not return to California. Petitioner's daughter continues to reside in Illinois.

Conclusions of Law

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

The Arbitrator concludes that all of the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

Respondent stipulated that Petitioner's current condition of ill-being was causally related to the accident and presented no evidence that the medical treatment provided to Petitioner was either unreasonable or unnecessary.

In regard to disputed issues (L) and (O) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes Petitioner is entitled to maintenance benefits of 178 4/7 weeks commencing August 7, 2013, through January 13, 2017.

The Arbitrator concludes Petitioner is entitled to vocational rehabilitation services and that the services are to be provided by someone other than the vocational rehabilitation experts who previously provided services to or evaluated Petitioner.

In support of these conclusions the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident and his current condition of ill-being was causally related to same.

The work restrictions imposed by both Dr. De Lucia, Petitioner's treating physician, and Dr. Komnick, Respondent's Section 12 examiner, were essentially identical to each other.

There was no dispute that, given Petitioner's work restrictions, he was not able to return to work to the job he had at the time of the accident.

The vocational services initially provided to Petitioner by Corvel were flawed and the opinions of their vocational experts were of little or no probative value. Petitioner was never tested by them and Corvel provided numerous job leads for positions that Petitioner was clearly not qualified for or which exceeded his work restrictions.

The vocational experts subsequently retained by Petitioner and Respondent, Ragains and Hammond, respectively, were both very critical of the rehabilitation services provided by Corvel, in particular, providing Petitioner with job leads for positions that he was not qualified for or which exceeded his work restrictions. Therefore, the Arbitrator has determined that Petitioner has not had ample assistance in regard to vocational rehabilitation services.

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

Ana Elizabeth Suits,

Petitioner,

vs. NO: 14WC 20415

Marquette Group,

18IWCC0587

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, 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 January 6, 2017 is hereby affirmed and adopted.

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

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

18IWCC0587

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: SEP 28 2018

Charles J. DeVriendt

Joshua D. Luskin

o073118
CJD/rlc
049

Special Concurrence

I concur with the result reached by the majority. I write separately as I utilized a different analysis of the "in the course of" and "arising out of" components to arrive at the decision.

Petitioner slipped and fell on two separate occasions, June 6, 2012 and November 14, 2012 while walking on a public sidewalk during her break. She was not on Respondent's premises when the falls occurred nor did Respondent maintain or control the sidewalks where Petitioner fell.

"This court has repeatedly held that "when an employee slips and falls, or is otherwise injured, at a point off the employer's premises while traveling to or from work, his injuries are not compensable.' [citations omitted]. Prior decisions of this court have noted two exceptions to this general rule." *Illinois Bell Telephone Company v. The Industrial Commission*, 131 Ill. 2d 478, 483-84, 546 N.E.2d 603 (1989). A claimant's injury can be deemed to occur "in the course of" the employment 1) if the injury is sustained in a parking lot maintained or controlled by the employer, or 2) if the employee's presence is required while performing her job duties and she is exposed to a common risk to a greater degree than the general public. *Id.* Petitioner was injured on a public sidewalk and not in a parking lot, so the first exception is inapplicable. The second exception is no more applicable. Petitioner's presence on the public sidewalk was not required in performance of her job duties. The facts in the present case are unlike those presented in *Bommarito v. Industrial Commission*, 82 Ill. 2d 191 (1980) or *Brais v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 120820WC where the claimants were required to use a certain route to access the employers' premises. Here, Petitioner was merely walking on a public sidewalk when she fell.

Petitioner argues the "in the course of" requirement is satisfied under the personal-comfort doctrine. "In lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains an injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment. [citations omitted]." *Eagle Discount Supermarket v. Industrial Commission*, 82 Ill. 2d 331, 340, 412 N.E.2d 492 (1980). Petitioner was not on her lunch break *per se* but the same reasoning applies. Petitioner requests we expand the personal-comfort doctrine to extend

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to off-premises breaks but such expansion was rejected by the Supreme Court of Illinois in *Lynch Special Services v. Industrial Commission*, 76 Ill. 2d 81, 389 N.E.2d 1146 (1979). The personal-comfort simply does not apply.

Even assuming *arguendo*, Petitioner proved her falls occurred "in the course of" her employment, she failed to prove her injuries "arose out of" her employment. Regarding falls, "a claimant must present evidence supporting a reasonable inference that the fall stemmed from an employment-related risk. After all, the 'arising out of' requirement contemplates 'a causal connection between the accidental injury and some risk incidental to or connected with the activity an employee must do to fulfill [her] duties.' *Stapleton, 282 Ill. App. 3d at 15*. Awarding compensation for a purely unexplained fall would eviscerate this requirement." *Builders Square v. The Industrial Commission*, 339 Ill. App. 3d 1006, 1010, 791 N.E.2d 1308 (2003).

Regarding her fall of November 14, 2012, Petitioner testified she did not know what caused her to fall. Therefore, it is incumbent on Petitioner to set forth sufficient evidence from which it can be inferred her fall was work-related. Petitioner failed to do so.

Regarding her fall of June 6, 2012, Petitioner testified she fell on a raised piece of concrete. Petitioner failed to present any evidence such concrete was a hazardous condition. Petitioner presented no evidence suggesting that the sidewalk was more hazardous or different than any other sidewalk. There is simply no evidence the sidewalk and the lip of concrete was defective or hazardous.

Accordingly, for the reasons set forth above, I concur with the decision of the majority.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUITE, ANNA ELIZABETH
Employee/Petitioner

Case# **14WC020415**
14WC020315

MARQUETTE GROUP
Employer/Respondent

18IWCC0587

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

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

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0507 RUSIN & MACIOROWSKI LTD
THOMAS P CROWLEY
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606-3833

18IWCC0587

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Anna Elizabeth Suits
Employee/Petitioner

v.

Marquette Group
Employer/Respondent

Case # **14** WC **20415**

Consolidated cases: **14 WC 20315**

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 **Nowak**, Arbitrator of the Commission, in the city of **Peoria, IL**, on **3/22/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **11/14/12**, 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 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 **$28,964.00**; the average weekly wage was **$557.00**.

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

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

ORDER

Because Petitioner failed to meet her burden of establishing that an accident occurred which arose out of and in the course of her employment with Respondent, 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

12/20/16
Date

JAN 6 - 2017

18IWCC0587

FINDINGS OF FACT

The Petitioner worked for the Respondent in the position of interactive product specialist. In this position she created and managed interactive campaigns for assigned product categories across multiple venders. She also insured customer satisfaction through regular and consistent communication with clients, account teams, and internal partners. This was largely a computer based sedentary position. The Petitioner began working for the Respondent in 2008.

The Petitioner testified she was entitled to two break periods during the day, in addition to a one half hour lunch period. The two 15 minute breaks were broken down into one break in the morning, and one break in the afternoon. There were no restrictions given by the Respondent as to where or how the employees could take their 15 minute breaks. The Petitioner testified that employees of the Respondent would leave the Respondent's place of business during their breaks and were free to do so without punishment or admonition by the Respondent.

The Petitioner testified that she would regularly leave the Respondent's place of business and go outside to the public sidewalks or walkways for her break and walk with a co-worker. Petitioner testified that her job was stressful and that she wanted to get outside and get some fresh air to clear her mind to focus on the remainder of her tasks for the rest of the day.

On June 6, 2012 the Petitioner was walking with a co-worker outside on a public sidewalk, approximately three blocks from the Respondent's location. The Respondent did not own, maintain, or in any other way control the condition of the sidewalk where the Petitioner was walking. Petitioner testified she tripped on a raised portion of the sidewalk and fell to her hands and knees, injuring her right elbow.

On the date of injury Petitioner presented to Procter First Care complaining of a ground level fall with injury. She complained of pain to the right elbow and forearm. X-rays revealed a possible occult fracture in the right elbow. (Px.3)

On the day following the accident, Petitioner sent an e-mail to her supervisor indicating she had fractured her elbow and needed to see an orthopedic doctor. (Rx.10)

Petitioner came under the care of Dr. Maxey at Great Plains Orthopedics. She underwent an MRI on August 9, 2012. Petitioner returned to Dr. Maxey on August 15, 2012. He interpreted the MRI to show an impact fracture of the lateral humeral condyle with some edema and a strain of the radial collateral ligament. The doctor suggested working on active extension of the elbow and return to see him in six weeks. (Px.5)

On November 14, 2012 the Petitioner was walking with a co-worker outside on a public sidewalk, across the street from the Respondent's location. The Respondent did not own, maintain, or in any other way control the condition of the sidewalk where the Petitioner was walking. The Petitioner testified she fell on the sidewalk, and did not recall why she fell or what caused her to fall.

The day after the accident, Petitioner sent an e-mail to her supervisor, Deb Monge. The e-mail indicates the Petitioner was going to see her doctor over the lunch break as she fell yesterday on a walk and may have re-injured her arm (Rx.4)

The Petitioner followed-up with Dr. Maxey on November 20, 2012. Dr. Maxey noted that she was doing much better and then she had another fall landing on the right elbow about a week ago. The Petitioner stated her elbow did not feel as bad as it did the first time she injured it and felt that she had more mild pain at this time. X-rays were taken on November 15, 2012 and Dr. Maxey noted although no fracture was evident there was a small effusion and there was concern there could be a non-displaced elbow fracture. He recommended supportive care and treat her elbow as a contusion with active range of motion and she could be seen back in the office to repeat her exam and x-rays in about one month (Px.5)

The Petitioner testified that she was called back to work for Mitsubishi Corporation in March of 2013 and was pursuing that avenue when she followed-up with Dr. Maxey on April 5. 2013. Dr. Maxey's records state she had not followed-up since last fall when she was seen after injuring her elbow. X-rays were taken that showed heterotopic ossification at the joint line in the lateral compartment of the elbow. Dr. Maxey wanted her to see Dr. Rashid to see if resection of the heterotopic ossification would be necessary, otherwise she could see Dr. Maxey as needed. (Px.5)

The Petitioner was seen by Dr. Mary Elizabeth Rashid on April 9, 2013. The history provided shows that the Petitioner possibly sustained a right lateral humeral condyle fracture that was minimally displaced and radial head fracture. She had elbow fractures in both June and November. Her main complaint was pain in the elbow as well as decreased range of motion and the Petitioner was concerned because she was going back to work at the end of April and she was concerned she would not be able to perform her work duties (Px.5)

Dr. Rashid reviewed the imaging studies including the x-rays and the MRI which showed some heterotopic ossification along the lateral aspect of the elbow in the collateral ligaments. Otherwise she had well healed fractures. Dr. Rashid's assessment was a 50 year old right hand female status post right lateral humeral condyle fracture and radial head fracture who had decreased range of motion, heterotopic ossification on the lateral aspect of her elbow and some pain. She has never done any therapy. Dr. Rashid felt that the Petition would make some gains with therapy and her pain could be relieved with a corticosteroid injection which she wanted to consider. She was to be seen back in three weeks (Px.5)

The Petitioner returned to Dr. Rashid on April 26, 2013 and underwent a corticosteroid injection (Px.5) She had still not had the physical therapy that was recommended. The Petitioner testified in June of 2013, she ended her employment relationship with Respondent and began working for another advertising agency group.

The Petitioner had no additional treatment until January 28, 2014. On that date she was seen by Dr. Rashid who noted that she had a corticosteroid injection in April of 2013 that seemed to help her pain. She stated her elbow went out over the weekend and she had a significant amount of pain. X-rays were performed of the right wrist what showed no widening at the DRUJ and she was slightly ulnar positive by 2 mm otherwise no abnormalities. Elbow x-rays were also taken which were interpreted to show good alignment of the radiocapitellar joint and some heterotopic ossification along the lateral aspect of the elbow. Dr. Rashid's assessment was a sensation of relative instability in the right elbow when performing heavy duty activities. She did not seem to have a medical collateral ligament tear on the MRI that was performed a few years ago and she is not apprehensive, and does not have instability on the lateral pivot shift test (Px.5)

Dr. Rashid recommended another MRI to evaluate this including the right wrist to evaluate the TFCC as well as MRI of the forearm to see if the interosseous membrane between the radius and ulna is intact.

The Petitioner had an MRI of the right wrist and MRI of the right forearm on February 11, 2014. The radiologist's impression was a triangular fibrocartilage tear and probable tear of the lateral collateral ligament complex in the right elbow. (Px.5)

The Petitioner followed-up with Dr. Rashid at Great Plains Orthopedics on February 21, 2014. The MRI was reviewed and the diagnosis was a right lateral collateral tear of the right elbow. Dr. Rashid recommended therapy to work on strengthening and surgical care would be a last resort as the Petitioner was stable on exam when she was examined the last time (Px.5).

The Petitioner followed-up with Dr. Rashid on April 11, 2014. Petitioner noted feeling of instability and difficulty pushing herself up out of a chair. She has been doing therapy which does not feel like it is improving her symptoms. Dr. Rashid noted that the Petitioner may be a candidate for examination under anesthesia and reconstruction of the lateral collateral ligament as she was not able to create the feeling of instability on examination. Dr. Rashid suggested that she wanted Dr. Garst to see the Petitioner to get his opinion (Px.5)

The Petitioner was seen by Dr. Garst at Great Plains Orthopedics on May 13, 2014. Dr. Garst recalled the episodes of her injuring her elbow a couple years ago which went on to heal but now she has problems with her elbow and has had ever since. She cannot straighten her elbow out all the way. Dr. Garst was not able to elicit instability of the elbow. Dr. Garst felt that she was a good candidate for ligament reconstruction and was going to refer her to the Mayo Clinic otherwise to a different tertiary care center (Px.5) The Petitioner did not receive treatment at the Mayo Clinic, but instead opted to treat at Northwestern University Hospital.

She was first seen by Dr. Matthew Saltzman at Northwestern Medical Foundation on August 21, 2014. Dr. Saltzman reviewed x-rays taken of her elbow which showed a congruent elbow joint. There were multiple calcifications laterally around the epicondyle and around the capitellum as well. There was no obvious fracture or deformity. An MRI from 2012 shows a partial lateral collateral ligament disruption from 2012. Dr. Saltzman recommended a new MRI arthrogram to evaluate for possible complete disruption of her lateral ligament complex (Px.6)

An MRI was performed on August 21, 2014 that showed a full thickness tear of the lateral collateral ligament which was old, thickening of the common extensor tendon origin which was also irregular and partially avulsed which was chronic, thin lateral half of the articular cartilage, irregular and demonstrated full-thickness cartilage loss in the capitellum, a 6 x 12 mm loose body in the olecranon fossa and a first degree strain of the brachialis and pronator teres and ulnar collateral ligament tendinosis (Px.7)

Petitioner followed-up with Dr. Saltzman on September 2, 2014. The treatment plan was decided to be a surgical treatment consisting of an arthrotomy and evaluation of the radial head and capitellum and removal of the loose body and lateral collateral ligament with reconstruction with allograft tendon (Px.6).

Petitioner underwent surgery by Dr. Saltzman on November 21, 2014. The postoperative diagnoses were posterior rotary instability of the elbow, complete lateral collateral disruption, and chronic postural lateral elbow instability. Dr. Saltzman performed a right open lateral collateral ligament reconstruction in the right

elbow, right elbow harvesting of palmaris longus autograft, right lateral capsular repair, and right elbow examination under anesthesia with inter-operative fluoroscopy (Px.6)

Petitioner followed-up with Dr. Saltzman on December 9, 2014 for her first postoperative appointment. Dr. Saltzman's assessment was a 53 year old status post LCL reconstruction with palmaris longus autograft who was doing well. She should continue to work on range of motion with her forearm in a pronated position. She was given a referral for formal physical therapy and he did not want her lifting more than five pounds with the hand until she was seen back in one month. She was having minimal pain (Px.6)

Petitioner was last seen by Dr. Saltzman on January 20, 2015 two months status post lateral collateral reconstruction with palmaris longus autograft. She had some erythema and drainage from the harvesting site and has been on Keflex and now reports no erythema or drainage for the last several days. Dr. Saltzman's assessment was a 53 year old had a likely stitch abscess from a palmaris longus harvesting site but there were no signs of active infection. Her elbow felt stable and she was very happy with the result. Her range of motion was coming along and she would be seen back in two months unless she develops problems (Px.6) Petitioner testified that she has not seen Dr. Saltzman or had any other medical treatment to her right upper extremity since January 20, 2015.

The Petitioner is claiming one week of TTD benefits from the date of surgery of November 21, 2014 through November 28, 2014.

CONCLUSIONS

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

In a workers' compensation case, the claimant has the burden of establishing by a preponderance of the evidence that her injury arose out of and in the course of her employment. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 223, 38 Ill. Dec. 133 (1980). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 605, 137 Ill. Dec. 658 (1989). "In the course of" the employment refers to the time, place, and circumstances under which the claimant is injured. *Scheffler Greenhouses, Inc. v. Industrial Comm'n*, 66 Ill. 2d 361, 366-67, 362 N.E.2d 325, 327, 5 Ill. Dec. 854 (1977).

"Arising out of" the employment refers to the origin or cause of the claimant's injury. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 672, 278 Ill. Dec. 70 (2003). An accident arises out of one's employment if its origin is in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667, 133 Ill. Dec. 454 (1989). "Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties." *Id.*, 129 Ill. 2d at 58, 541 N.E.2d at 667. "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Id.*, 129 Ill. 2d at 58, 541 N.E.2d at 667.

There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 806, 247 Ill. Dec. 22 (2000). Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Id.*, 314 Ill. App. 3d at 163, 731 N.E.2d at 806-07. Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 117, 881 N.E.2d 523, 527, 317 Ill. Dec. 355 (2007).

On June 6, 2012 Petitioner was taking a walk, which was her usual routine during her regularly-scheduled break time. Petitioner testified that she takes walks to relieve stress and clear her mind so she could focus on her tasks for the rest of the day. In this case Petitioner had ventured off the employer's premises. Petitioner was walking with a co-worker outside on a public sidewalk, approximately three blocks from the Respondent's location. The Respondent did not own, maintain, or in any other way control the condition of the sidewalk where the Petitioner was walking. Petitioner testified she tripped on a raised portion of the sidewalk and fell to her hands and knees, injuring her right elbow.

On November 14, 2012 the Petitioner was again walking with a co-worker outside on a public sidewalk, across the street from the Respondent's location. The Respondent did not own, maintain, or in any other way control the condition of the sidewalk where the Petitioner was walking. The Petitioner testified she fell on the sidewalk, and did not recall why she fell or what caused her to fall.

The risk encountered in these instances was a neutral risk. Although Petitioner took walks frequently during her break periods, she was in no way required to do so. The Arbitrator concludes the risk to which Petitioner was exposed is one to which the public at large was also exposed and that to the extent that Petitioner was exposed to this risk more frequently than some members of the public at large, the frequency was determined by Petitioner herself. Therefore, the Arbitrator finds the Petitioner's accident did not arise out of her employment with the Respondent.

"A compensable injury occurs 'in the course of' employment when it is sustained while a claimant is at work or while he performs reasonable activities in conjunction with his employment." *Wise v. Industrial Comm'n*, 54 Ill. 2d 138, 142, 295 N.E.2d 459, 461 (1973). "If the injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of his duties and while he is performing those duties or doing something incidental thereto, the injury is deemed to have occurred in the course of employment." *Eagle Discount Supermarket v. Industrial Comm'n*, 82 Ill.2d 331, 338 (1980) (citation omitted). *Eagle Discount Supermarket* is one of a series of cases which involve injuries sustained on lunch hours or breaks. The Court in *Eagle Discount Supermarket* went on to state:

> In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains an injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment.

> Since eating is deemed to be an act of personal comfort, the personal comfort doctrine has been applied to cases involving lunchtime injuries. Under the personal comfort doctrine, the course of employment is not considered broken by certain acts relating to the personal comfort of the employee. Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort. (See, e.g., *Sparks Milling Co. v. Industrial Com.* (1920), 293 Ill. 350 (getting fresh air); *Union Starch v. Industrial Com.* (1974), 56 Ill. 2d 272 (seeking relief from heat); *Scheffler Greenhouses, Inc. v. Industrial Com.* (1977), 66 Ill. 2d 361 (seeking relief from heat and humidity); *Chicago Extruded Metals v. Industrial Com.* (1979), 77 Ill. 2d 81 (showering in locker room provided by employer).) *Id.* at 339-40 (citations omitted, emphasis added)

In these cases, however the injuries occurred on the employers premises. In this case Petitioner's falls, by her own admission did not occur on Respondent's premises. Petitioner testified she went on walks during her break periods in order to get outside and get some fresh air to clear her mind to focus on the remainder of her tasks for the rest of the day. Although this may be deemed an activity for her personal comfort, the injury occurred not on the Respondent's premises. but on a public sidewalk outside of Respondent's premises that Respondent did not own, maintain or control. Therefore, the Arbitrator finds the "personal comfort" doctrine does not apply and concludes Petitioner's accident did not occur in the course of her employment with the Respondent.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to sustain her burden of establishing that she sustained an accident which arose out of and in the course of her employment. All other issues are moot. Benefits are, therefore 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 COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Letricia A. Davis,

Petitioner,

vs. NO: 11 WC 06741

Addus Healthcare,

Respondent.

18IWCC0588

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 2018 is hereby affirmed and adopted.

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

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

DATED: SEP 28 2018
SJM/sj
o-9/20/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAVIS, LeTRICIA
Employee/Petitioner

Case# **11WC006741**

ADDUS HEALTHCARE
Employer/Respondent

18IWCC0588

On 3/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% 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:

2902 LAW OFFICES OF PETER G LEKAS
5357 W DEVON AVE
CHICAGO, IL 60646

0766 HENNESSY & ROACH PC
ERICA A LEVIN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

18IWCC0588

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

LeTricia Davis
Employee/Petitioner

v.

Addus Healthcare
Employer/Respondent

Case # 11 WC 06741

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **January 9, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/16/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$10,561.95**; the average weekly wage was **$271.69**.

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

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

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

Respondent shall be given a credit of **$0** 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 claim for compensation is **denied**, Petitioner **failed to prove** by a preponderance of the credible evidence that she sustained an **accidental injury** that **arose out of and in the course** of her employment by Respondent on January 16, 2011. Because of the Arbitrator's findings, all other issues are moot and need not be addressed.

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

3/20/2018
Date

MAR 20 2018

FINDINGS OF FACT

On January 6, 2011, LeTricia Davis (hereinafter referred to as "Petitioner") was employed by Addus Healthcare (hereinafter referred to as "Respondent") as a home health aide. Petitioner testified that on January 6, 2011 she was traveling from her home to her client's home when she was involved in a motor vehicle accident. Petitioner was driving her personal vehicle at the time of the accident. Petitioner testified that she stopped at Pete's Produce to pick up bananas and strawberries for her client. Petitioner testified the client had asked Petitioner to pick up the items the previous evening but did not give Petitioner money to pick up these items. Petitioner said she used her own money. Petitioner testified she did not recall if she picked up anything else from Pete's Produce. Petitioner testified that she did not submit a request for reimbursement of the item she picked up at Pete's Produce nor did Petitioner submit a request for mileage reimbursement for running the errand. Petitioner testified that, depending her relationship with the clients, she would be paid by the client either before or after picking up the client's items.

Grene Thompson testified for Respondent. Ms. Thompson was employed by Respondent, as a service coordinator. Ms. Thompson testified that an employee's shift begins once the employee arrives at the client's home and the employee clocks-in. An employee clocks-in when they arrive at the client's home and they call a toll-free number, from the client's home, which records the employee's clocks-in and clocks-out time. (T. pg. 55). Ms. Thompson testified employees are allowed to run errands for clients after the employee arrives at the client's home and clocks-in. (T. pgs. 48, 49). Ms. Thompson testified that Respondent reimburses mileage for errands after the employee arrives at a client's home and after the employee clocks-in. Ms. Thompson testified that she had never run across a situation where an employee ran an errand for a client either before or after work and submitted a request for mileage reimbursement. (T. pg. 55).

The Respondent's mileage Policy states that employees are not reimbursed for mileage going to and from the employee's home and first visit to a client.. Pursuant to the Policy, employees are entitled to mileage reimbursement for running errands which are necessary to support in-home client care subject to review and approval. Under Respondent's policy, it is the employee's responsibility to track and turn in mileage and other expenses requests and mileage requests must be turned in at the end of each week. (RX 2).

Under the Respondent's Personally Owned Vehicle Policy states that all accidents which the employee driver is involved in while driving a car on company business must be reported immediately to the Agency Director or designated administrative staff person. All other accidents and moving violations that occur outside of company business must also be reported to the Agency Director or designated administrative staff person within 24 hours of an occurrence or next business day. (RX 3).

Ms. Thompson testified that Petitioner reported that she was involved in a car accident on January 6, 2011. Ms. Thompson testified that Petitioner did not did not report she had ran an errand for a client prior to arriving at the client's home and when the accident had occurred. Ms. Thompson further testified that she became aware Petitioner was claiming to have run an errand for a client prior to arriving at a client's home was in October of 2017. (T. pg. 52). On January 31, 2011, Petitioner completed an Employee of Injury Report and Statement. On that Report, wrote that the accident had occurred when "Heading to work, client, I was driving to 3105 Marion, Melrose Park, Ill.". (RX 4).

Petitioner testified that she was involved in an automobile accident on January 6, 2011 while on I-55 near Harlem Ave. after leaving Pete's Produce. Petitioner said she had picked up some fruit for a client after leaving home while she was on her way to a client's home. Petitioner testified the client had asked her to pick up the fruit the previous evening. After leaving Pete's Produce, Petitioner honked her horn at a girl who was sitting at a green light on California Ave. Petitioner then went around the girl and merged onto I 55. Petitioner testified as she approached Harlem Ave. the girl jumped in front of her and seemed like she was playing a game and it was like road rage. Petitioner testified she changed lanes and so did the girl. Petitioner testified that after the girl changed lanes she stopped and Petitioner attempted to stop and lost control of her car. Petitioner did not know what happened after that. Petitioner testified immediately after the accident she noticed that she had coffee all over her and that her wig flew off. Petitioner testified that she was holding her chest cavity area because of pain caused by the deployment of the airbag. Petitioner was taken to MacNeal Hospital by ambulance. (T. pgs. 17-20).

After being released from MacNeal Hospital, Petitioner followed up with Dr. James Schiappa at Holy Cross Hospital. On January 12, 2011 reported right hand, cervical and chest pain. No specific diagnosis was listed but Petitioner was authorized off work for 4 weeks. (PX. 2) A CT of the chest performed at Preferred Open MRI on January 13, 2011 showed no active cardiopulmonary process and no chest wall abnormality. On January 19, 2011, Petitioner presented to Marquette Physical Therapy and Petitioner reported no past history of injury to the cervical or lumbar spine or right hand. Petitioner was to attend therapy three times per week for three weeks.

On January 21, 2011, Petitioner presented to Dr. Ignas Labanauskas at Holy Cross Hospital for evaluation of left chest wall and left thumb injuries. Dr. Labanauskas reported that Petitioner had previously been seen for "numerous conditions" including a right rotator cuff condition and ankle injury she had in 2006. Dr. Labanauskas noted the x-rays taken of the lumbar spine, right knee, chest and hands and shoulder were all unremarkable. Dr. Labanauskas recommended continuing with pain medication and completing physical therapy. Petitioner returned to Dr. Labanauskas on March 2, 2011. At that visit, Petitioner reported significant symptoms with multiple areas. Petitioner was prescribed Celebrex and advised to finish physical therapy.

Petitioner returned to Dr. Labanauskas on April 19, 2012. Petitioner reported that she was not getting any better and she would like to pursue further treatment. Petitioner was given a prescription for MRIs of the right and left shoulders. Petitioner also reports prolonged sitting and that she developed locking and triggering of her right fourth finger which she said started after the motor vehicle accident. In his records, Dr. Labanauskas wrote that he did not note Petitioner's new complaints before and that it is hard to related whether her new complaints are related to a traumatic event. Dr. Labanauskas diagnosed right fourth finder flexor tendon stenosis tenosynovitis and recommended surgery. The surgery was performed on May 31, 2012. It appears that Petitioner returned to Dr. Labanauskas on November 14, 2012 and January 16, 2013. The medical records from Dr. Labanauskas do not contain a record for the November 14, 2012 date. Dr. Labanauskas released Petitioner from care on January 16, 2013. (PX 2).

On August 14, 2013, Petitioner returned to Dr. Schiappa for evaluation of lower back and hand pain following a motor vehicle accident on June 28, 2013. She reported pain in the low area left side SI joint with no improvement since the accident. Petitioner was referred to Dr. Schaffer for a second opinion. On this same date Dr. Leslie Schaffer noted that Petitioner suffers from lumbar radiculitis and an MRI was proscribed. On November 29, 2013 Petitioner underwent an MRI of the left hip based upon left hip pain status post MVA. There were no additional medical records submitted into evidence.

At trial, Petitioner testified that she experiences pain in the lower back, lower abdomen, left hip, left knee and right ring finger. She reported that she is currently undergoing treatment with Dr. Ravi Kasi at Rehabilitation of Rush and that she uses Lidocaine patches to address her pain complaints. Petitioner also testified she uses the patches for her herniated disc or whatever she had from the accident. (T. pgs. 34-37)

The Arbitrator did not find the testimony of 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. 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)) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). The purpose of the Act is to protect employees against risks and hazards which are peculiar to the nature of the work they are employed to do. *Orsini v. Industrial Comm'n*, 117 Ill.2d. 38, 44, 509 N.E.2nd 1005, 1008, 109 Ill. Dec. 166 (1987).

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

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* (West 2008). The general rule is that an injury occurred by an employee is going to or returning from the place of employment does not arise out of or in the course of the employment and is not compensable. *The Venture-Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Comm'n*, 2013 IL 11572, 376 Ill. Dec. 823 (*quoting Commonwealth Edison Co. v. Industrial Comm'n*, 86 Ill.2d 534, 56 Ill.Dec. 846, 428 N.E.2d 165 (1981). An exception to the general rule involves a traveling employee whose work duties require the employee to travel away from the employer's premises. *Id.* A traveling employee is deemed to be in the course of his employment from the time that he leaves his home until her returns. *Kertis*, 2013 IL. App. (2d) 12052WC, 372 Ill.Dec.378, 991N.E.2d 868; *Mlynarczyk v. Illinois Workers' Compensation Comm'n*, 2013 IL. App (3d) 120411WC, 376 Ill.Dec. 536, 999 N.E.2d 711. An injury sustained by a traveling employee arises out of his employment if the employee was injured while engaged in conduct that was reasonable and foreseeable (*i.e. conduct that might normally be anticipated or foreseen by the employer*). *Robinson v. Industrial Comm'n*, 96 Ill.2s 87, 70 Ill.Dec. 232, 449 N.E.2d 106 (1983). The threshold question is that whether the claimant had embarked on a work-related trip at the time he was injured or whether he was merely beginning his regular commute to his employer's premises at that time (i.e. was he making his regular commute to a fixed jobsite as a necessary precondition to any subsequent work-related travel). *Lavon Pryor v. Illinois Worker's Compensation Comm'n*, 2-13-0874 WC, 27 N.E. 3d 678 (2nd Dist. 2015).

A finding that a claimant is a traveling employee, however, does not relieve the employee of the burden of proving that her injury arose out of and in the course of her employment. Venture-Newberg Perini Stone & Webster, 2012 IL.App. (4th) 110847 WC, 367 Ill.Dec. 363, 981 N.E. 2d 1091. The lest whether a traveling employee's injury arose out of and in the course of employment is the reasonableness of the conduct in which she was engaged at the time of the injury and whether the conduct might have been anticipated or foreseen by the employer. *Id.*

The Arbitrator has carefully reviewed and considered all the evidence and concludes that Petitioner has failed to prove by the preponderance of the evidence that she sustained an injury arising out of and in the course of her employment with Respondent on January 31, 2011, as set for the more fully below.

The Arbitrator finds that the Petitioner was not a traveling employee when she was driving in her personal car to a client's home. The accident occurred when Petitioner was on her way to the client's home. The Arbitrator finds that Petitioner's testimony that she stopped at Pete's Produce to pick up bananas and

strawberries for her client before arriving at work not to be credible. Such conduct would be in violation of Respondent's policies. Running errands are permitted only after the Petitioner arrives at the client's home and phones into a specific phone number using the client's phone. Therefore, the Arbitrator finds that Petitioner had not run an errand for a client while traveling to the client's home. Petitioner did not proffer any evidence collaborating her testimony such a receipt showing the purchase of bananas and strawberries at the time and location Petitioner claims to have stopped at Pete's produce. Pursuant to the Respondent's mileage policy, the receipt could be needed to support the reimbursement of mileage because frequency and type of errands are subject to AD review and approval.

The Arbitrator also notes that Petitioner did not report she had performed an errand until October of 2017. Ms. Thompson testified that she became aware Petitioner was claiming to have performed an errand on her way to work was on October of 2017. (T. pg. 52). The Employee of Injury Report and Statement, completed by Petitioner on January 31, 2011, does not indicate that Petitioner performed an errand for a client prior to the accident, only that Petitioner was "heading to work." (RX 4). The Arbitrator finds that Petitioner was making a regular commute to a fixed jobsite prior to any subsequent work-related travel. If the Petitioner had arrived at the client's home and clocked-in, she would have become a traveling employee for errands after complying with Respondent's policies and for traveling to the homes of other clients that day. Respondent's Personally Owned Vehicle Policy and Mileage Policy acknowledges situations when an employee should be considered a traveling employee.

Even assuming Petitioner was a traveling employee and the employee was running an errand before she arrived at her scheduled work place, Petitioner's conduct would not have been reasonably foreseeable. Pursuant to Respondent's policy, Petitioner was required to arrive at a Client's house and clock-in before prior to running any errands for clients. Taking a client to the store or picking up things for the client would be permitted pursuant to Respondent's policies only after the employee arrived at the client's home and clocked-in. Ms. Thompson testified that she had never had a situation where an employee had run an errand for a client either before or after work and submitted a request for mileage reimbursement. Petitioner did not proffer any testimony of prior examples showing that Respondent knew or should have known that employees were running errands in violation of Respondent's policies. Therefore, the Arbitrator finds that Petitioner's trip to the grocery store, prior to arriving at the client's home and clocking-in was not reasonable and foreseeable conduct.

WITH RESPECT TO ISSUES (F), (J), (K) AND (L), THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator's findings on this issue of accident, all other issues are moot and Respondent is not found liable for the payment of any benefits associated with this claim.

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

Eddie Harvey,

Petitioner,

vs. NO: 16WC029582

City of Chicago,

18IWCC0589

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical, temporary disability, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 6, 2018 is hereby affirmed and adopted.

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

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

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

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

DATED: SEP 28 2018
SJM/sj
o-9/20/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

HARVEY, EDDIE
Employee/Petitioner

Case# **16WC029582**

CITY OF CHICAGO
Employer/Respondent

18IWCC0589

On 4/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4564 ARGINIS & ASSOCIATES LLC
DANA BRISBON
180 N LASALLE ST SUITE 1925
CHICAGO, IL 60601

0113 CITY OF CHICAGO CORP COUNSEL
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

18IWCC0589

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)

Eddie Harvey
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **16** WC **29582**

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 **3/19/18**. 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. ☐ 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, **7/16/16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$69,283.32**; the average weekly wage was **$1,332.37**.

On the date of accident, Petitioner was **35** years of age, **married** with **4** dependent children.

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

Respondent shall be given a credit of **$40,607.55** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$40,607.55**.

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

ORDER

THE ARBITRATOR FINDS THE PETITIONER'S PRESENT CONDITION OF ILL BEING IS NOT CAUSALLY RELATED TO THE ACCIDENT CLAIMED IN THE MATTER AT BAR. COMPENSATION UNDER THE ACT 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.

#001 Arbitrator George Andros

Signature of Arbitrator

April 5, 2018

Date

ICArbDec19(b)

APR 6 - 2018

STATEMENT OF FACTS 16 WC 29582

The petitioner testified that he worked as a contrition laborer in the water Department for two years at the time of injury. He testified to injuring his groin hip and back at the time of injury. He also denied any priors to the back. Medical records indicate a 2012 discectomy, which he claims is a typo. That is unknown. He is 5'11" and 240 pounds. He is very articulate. Thus, the absence of early history of law back problems manifested in the case should not be associated with any language impairment or inability to communicate effectively about his symptoms.

The petitioner sustained suffered a right hip injury that caused pain in his inner though and groin on 7/6/2016 (two thousand sixteen) while in the course and scope of his employment with respondent. He was lifting a pipe when he felt a pain in his prion area.

Following his injury the petitioner reported to MercyWorks. He testified that he reported low back and groin pain. The medical records do not support his testimony as they only indicate a groin injury. He was diagnosed with a groin strain. Initially his physician's thought he had a hernia. That was disproved and a MRI ultimately established that he had a right labral tear in his hip. He received injections in his right hip joint. His symptoms continued. Therefore, he underwent a right hip arthroscopy labral repair on 11/30/16. The petitioner complained at trial that his symptoms did not improve after surgery.

In Dr. Akerman's 4/30/2017 (two thousand seventeen) report there was a discussion o the petitioner's pain. The doctor indicated that he would have expected "sharper pains" in contract to the stiffness the petitioner described with inactivity. The doctor opined that he would likely see improvements "upwards of a year out from surgery".

5/1/17 (two thousand seventeen) is the first time there is any mention of low back pain in the petitioner's medical records.

Dr. Akerman's notes of 5/22/17 indicate that he spoke with petitioner's therapist and that she felt he had progressed appropriately and met his milestones. Some hip soreness was described and again a lumbar MRI was recommended. The doctor commented that while the petitioner may have some initial soreness he was released to full duty.

10/3/17 notes from Swedish Covent clearly indicate the he did not initially feel back pain. An injection to the low back was recommended. The petitioner has not had said injection. He is seeking authorization for the injection. Petitioner claims that he is in constant pain with a stabbing pain that radiates into his right leg daily. The petitioner returned to his usual and customary position with respondent. He is able to perform the duties of his job.

CONCLUSIONS OF LAW

An injury "arises out of one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Jewel Cos. v. Industrial Comm'n (1974), 57 Ill.2d 38, 40, 310 N.E.2d 12.* The burden is on the party seeking an award to prove by the preponderance of the credible evidence the elements of her claim. *Peoria County Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E. 2d 1026 (1987).* The burden is also on the employee to prove that her injuries are causally related to the employment. *Newgard v. Industrial Commission , 58 Ill.2d 164, 317 N.E. 2d 524 (1974).*

Petitioner alleges that his back injury is related to his initial work injury and seeks treatment for the low back as a result. His claim is not at all supported by the evidence.

His testimony contradicted the medical records. He claimed that he injured his low back on 7/6/16. The initial medical records do not support his testimony, however. They only support a groin and right hip injury.

The first time his low back is mentioned in his records is in May of 2017 a good eleven months later. This is a substantial lapse of time that has not been satisfactorily explained by the petitioner. There is no reason of legal significance at the IWCC in determining this matter , that the back is not mentioned at all in any of the records for this time period. The only conclusion that the Arbitrator can draw is that the petitioner did not injure his low back on 7/6/16. There is nothing in the records to suggest that he injured it during his treatment for his hip either.

Thus, based upon the totality of the evidence. This etitioner did not establish that the back condition he asserts in the case at bar is causally connected to the accident/ injury date of 7/6/2016(two thousand sixteen) As such his claim for medical treatment to the low back under the Act must be denied.

The Arbitrator further sayeth naught.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Warren,

Petitioner,

vs. NO: 13WC026486

Village of Oak Brook,

18IWCC0590

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 medical expenses, prospective medical care, causal connection, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 14, 2017 is hereby affirmed and adopted.

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

No bond is required for 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: SEP 28 2018

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

SJM/sj
o-9/20/2018
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARREN, SCOTT
Employee/Petitioner

Case# **13WC026486**

VILLAGE OF OAK BROOK
Employer/Respondent

18IWCC0590

On 12/14/2017, 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 1.46% 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:

0159 LAW OFFICE OF FRANCIS DISCIPIO
1200 HARGER RD
SUITE 500
OAK BROOK, IL 60523

0075 POWER & CRONIN LTD
ELENA CINCIONE
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

18IWCC0590

☐ 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

Scott Warren
Employee/Petitioner

v.

Village of Oak Brook
Employer/Respondent

Case # **13** WC **26486**

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 **Wheaton**, on **October 26, 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

18IWCC0590

On **June 25, 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 **$127,562.70**; the average weekly wage was **$2,453.12**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

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

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

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

Respondent is entitled to a credit of **$23,363.56** under Section 8(j) of the Act.

ORDER

Because the Petitioner failed to prove the issue of causation, 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

12/12/17
Date

DEC 14 2017

18IWCC0590

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on June 25, 2011. Respondent is disputing Petitioner's claims and the issue in dispute are: 1) accident, 2) notice, 3) causation, 4) medical expenses, 5) TTD, and 6) permanency.

Petitioner works for Respondent as a police officer. He testified that on June 25, 2011 he was called to the scene of a retail theft. Once on the scene, he interacted with the suspects and fell while trying to apprehend an uncooperative suspect. He testified that after the incident he prepared a police report and other memoranda documenting the events. He also testified that he did not draft a memorandum that indicated he injured his right knee during that incident. He told Sergeant Birdsall about the incident, but did not testify that he reported a work-related injury to his right knee to Sgt. Birdsall. Sgt. Birdsall was not called as a witness. Sergeant King testified on behalf of Respondent. He was Petitioner's supervisor in June 2011, but was not working on the date in question and Sgt. Birdsall was working as Petitioner's supervisor on said date. He testified that there is no documentation of Petitioner sustaining a work-related injury on June 25, 2011.

Both the Petitioner and Sergeant King testified to the Respondent's required procedure when an employee is injured. Petitioner testified he follows that procedure. He also testified that he has been injured at work before and has always documented the injuries. Both Petitioner and Respondent exhibits include documentation memoranda completed by Petitioner regarding past injuries at work.

The Petitioner has a documented history of knee complaints pre-dating June 25, 2011. Subsequent to June 25, 2011 Petitioner first sought medical treatment for his right knee with Wheaton Orthopedics on May 25, 2012. On April 18, 2012 Petitioner underwent an MRI of the right knee. On August 15, 2013 Petitioner underwent surgery to the right knee in the form of arthroscopy with chondroplasty to treat grade 3 chondromalacia. He underwent physical therapy post-operatively and was able to return to work full duty on October 17, 2013. Dr. Kellen Choi discharged the Petitioner from care on December 6, 2013.

On July 10, 2013, Petitioner underwent an independent medical examination by Dr. Bryan Neal at the Respondent's request. (See RX 2) As part of his examination, Dr. Neal went through a thorough review of Petitioner's medical history, noting Petitioner's numerous prior right knee injuries and medical treatment. In light of the Petitioner's pre-existing knee condition, his prior knee injuries and the Petitioner's history of treatment, Dr. Neal did not believe Petitioner's current knee condition was causally related to his alleged June 25, 2011 accident.

Petitioner testified he has been working full duty without issue since October 17, 2013. When describing the activities he continues to engage in and the frequency with which he engages in them, it is apparent he continues to lead an active lifestyle and engages in sports activities multiple times per week.

There is an existing Illinois Workers' Compensation credit for 15% loss of use of the right leg as a result of 05WC16594.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony regarding the events he described occurring on June 25, 2011. Although Respondent disputes this issue based on the lack of documentation, their

18IWCC0590

own witness, Sgt. King testified that there are times when accident reports are not completed. There was no witness or evidence presented to rebut Petitioner's testimony regarding the incident he described that occurred on June 25, 2011 as he was attempting to apprehend a suspect. As such, the Arbitrator concludes that the Petitioner sustained an accident while working for the Respondent on June 25, 2011.

2. Regarding the issue of notice, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony that he informed his acting supervisor, Sgt. Birdsall about the events that transpired on June 25, 2011. Despite the dispute on this issue, Sgt. Birdsall was not called to testify by Respondent. Sgt. King was called to testify, but he indicated that he was not working on the date in question and admitted that there are times when accident reports are not completed despite the reporting of other events. Accordingly, the Arbitrator concludes that Petitioner provided sufficient notice of his June 25, 2011 accident.

3. With regard to the issue of causation, the Arbitrator finds that the Petitioner failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the medical evidence, which show that the Petitioner has had pre-existing knee problems and also notes the 11 month gap in treatment from the alleged date of accident to the first time Petitioner sought treatment for his knee following that date. While the Arbitrator finds the Petitioner credible, the Arbitrator is persuaded on this issue by the medical evidence. The medical records indicate that Petitioner had longstanding knee problems dating back to 2008. The diagnosis of arthritis was present and symptomatic for 3 years prior to June 2011. Additionally, the Petitioner waited 11 months to seek medical treatment for his knee. The gap in treatment is particularly persuasive to the Arbitrator. In addition to the time gap in treatment, the Arbitrator looks to Dr. Neal's Section 12 examination report admitted into evidence in which he opined that Petitioner's right knee condition is not causally related to the June 25, 2011 incident. Dr. Neal's opinion regarding causation is supported with a clear explanation as to the basis of his opinion. The remainder of the record, including trial exhibits is absent a contradictory opinion with an explained basis. Therefore, the Arbitrator finds the opinions of Dr. Neal persuasive on this issue and concludes that the Petitioner's current condition of ill-being is not causally related to his June 25, 2011 accident.

4. Based on the Arbitrator's findings regarding the issue of causation, all remaining issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Corina Bass,

Petitioner,

vs.

NO: 10 WC 47679

18IWCC0591

Joliet Public Schools, Dist. 86,

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 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 April 11, 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: SEP 28 2018
TJT:yl
o 9/25/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BASS, CORINA
Employee/Petitioner

Case# **10WC047679**

JOLIET PUBLIC SCHOOLS DISTRICT #86
Employer/Respondent

18IWCC0591

On 4/11/2016, 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:

0000 BRISKMAN BRISKMAN & GREENBERG
SUSAN FRANSEN
175 N CHICAGO ST
JOLIET, IL 60432

3998 ROSARIO CIBELLA LTD
JANE RYAN
116 N CHICAGO ST SUITE 600
JOLIET, IL 60432

18IWCC0591

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

Corina Bass
Employee/Petitioner

v.

Joliet Public Schools District #86
Employer/Respondent

Case # **10** WC **47679**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **New Lenox**, on **February 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 11, 2010,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$48,089.60**; the average weekly wage was **$924.80**.

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

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

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

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of **$22,195.08** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$22,195.08**.

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

ORDER

Medical Benefits

Medical benefits claimed after November 15, 2010 are denied.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$616.53**/week for **12 weeks**, commencing **08/12/2010 through 11/04/2010** , as provided in §8(b) of the Act.

Credit

Respondent is entitled to **$22,195.08** for TTD paid.

Permanent Disability

Respondent shall pay the sum of **$554.88**/week for a period of **50** weeks, as provided in §8 **(d) 2**of the Act, because the injuries sustained caused **10% loss of use of person as a whole.**

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

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

Christine Roy

Signature of Arbitrator

04/09/2016

Date

APR 1 1 2016

-BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Corina Bass	)	
Petitioner,	)	
vs.	)	**No. 10 WC 47679**
Joliet Public Schools, Dist. #86,	)	
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox on February 3, 2016. The parties agree that on August 11, 2010, the Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act; that their relationship was one of employee and employer, that petitioner suffered accidental injuries that arose out of and in the course of her employment with respondent. They agree that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $48,089.60, and that her average weekly wage was $924.80.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills.
3. What period of temporary total disability is due.
4. What is the nature and extent of petitioner's injury; including whether petitioner is permanently and totally disabled.
5. Whether penalties or fees should be imposed upon Respondent.
6. Whether petitioner exceeded her choice of doctors allowed pursuant to § 8 a.

FINDING OF FACTS

Petitioner testified she had been employed by respondent for 9-1/2 years before the work accident of August 11, 2010 in respondent's maintenance department. Before she worked for respondent she was a housewife. Before that she was employed as a factory worker, doing spot welding and picked and packed. She did not graduate from high school, but did obtain her GED. She had no special training or education. She was in good physical condition when she began her employment with respondent.

Her job with respondent required her to clean rooms, hallways, and other maintenance work. She was hired by respondent as a full time, union employee. Her job duties remained the same throughout her employment with respondent. During the school year period, which was September to June, petitioner would clean rooms, bathrooms and hallway.

During the summer, petitioner would do master cleaning, which entailed removing everything out of the classroom, strip the floor in the room and then return the desks and other furniture to the cleaned room. Petitioner would clean 45 to 50 classrooms during the summer. She worked with her partners, Diane McIntyre and George. She lifted the chair and desks by herself. All day long she did this lifting.

Petitioner had a prior workers' compensation claim for an injury she suffered to her back in 2003. She testified she recovered completely from that accident. She also had a prior hand injury from which she recovered and return to work full duty. In February, 2010, petitioner obtained treatment to her lower back and right leg and right knee. Petitioner had an EMG done; received a shot in her knee; was able to return to work full duty and worked full duty until August 11, 2010.

Petitioner testified that on August 11, 2010, she was removing furniture from a classroom to perform the master cleaning. Petitioner testified that as she was taking the chairs down, she felt a pop in her lower back on the right side. She reported the injury to her principal, Maria. The next morning, she was sent to Glenwood Clinic by respondent. She was treated by Dr. Dorning at the clinic, who released her to return to work and from his care, even though she was still on pain medication. She received an MRI on August 31, 2010.

Petitioner testified she then went to her own primary care doctor, Dr. Shah as she was not getting better. Dr. Shah referred her to pain doctor, Dr. Singh. Dr. Singh accused petitioner of not taking her pain medication as prescribed and refused to continue treating her. Petitioner testified she returned to Dr. Shah who then referred her to Dr. Cheema, another pain doctor. Dr. Cheema referred her to Dr. Templin, whom she first saw on July 19, 2011.

Dr. Templin performed a fusion on April 4, 2012. She was smoking a pack a day. The first fusion did not help. Dr. Templin referred petitioner to Pirie Chiro Clinic for physical therapy. On April 25, 2013, Dr. Templin, due to non-union, redid the spinal fusion. She now sees Dr. Templin about once a year.

Petitioner testified Dr. Shah had released petitioner to return to work full duty on November 4, 2010. Petitioner was doing pretty good until November 16, 2010 when her back locked up. She went to St. Joseph Hospital. She returned to work and continued working until Christmas break.

Petitioner testified that on January 4, 2011, her back went out and she was not able to return to work. She saw Dr. Shah that day. Dr. Shah took petitioner off work and ordered injections.

She testified she was released to return to work by Dr. Templin with permanent restrictions of no lifting greater than 10 pounds. Petitioner never asked her union or respondent if they could accommodate her return to work. Instead, she did her own job search (PX. 18 & 24). Petitioner testified respondent terminated her in February, 2011.

On May 18, 2015 petitioner was evaluated by vocational counselor, Joe Belmonte, of Vocamotive (PX.21). She testified that she had oxycodone in her purse that was her son's prescription that she did not take. She also testified she had her own prescription, but had run out.

Petitioner testified she was seeing Dr. Cheema on a monthly basis and is being prescribed Oxycodone, muscle relaxers and Ibuprofen. She is also taking blood pressure medication.

Petitioner testified she had been in a motor vehicle accident on December 16, 2011. She said she blacked out due to her high blood pressure. She claimed she only bumped another vehicle. She was admitted to Silver Cross Hospital to determine why she blacked out. She denied that her low back had been injured in the accident.

Petitioner testified she no longer goes to gym, bowls, wear high heels or walk the way she once did. Petitioner testified she has light pain all day and sometimes petitioner has pain she described as "stiff and hard", if she doesn't take her pain pills. She also gets radiating pain some times. She claims she cannot sit for greater than an hour (although petitioner sat and testified for over an hour without asking for a break or standing up.) Petitioner testified her back pain affects her sexual relations with her husband as it causes back pain. She was approved for social security disability in May, 2012.

Petitioner confirmed she had an EMG by Dr. Shah on January 27, 2010 EMG by Dr. Shah. She had a discogram on November 30, 2011 by Dr. Templin. Petitioner testified that on August 4, 2015 petitioner went to St. Joseph Hospital emergency rooms as her back locked up due to the fact that she got caught in traffic coming back from a trip. She took muscle relaxers and saw Dr. Shah in follow up after that.

On Cross examination, petitioner admitted she had removed only two to three small chairs from the room when the injury occurred. She also admitted she had an EMG done in February, 2010. She admitted she did not tell Dr. Mather that she had prior back problems in 2003. She denied that the reason she had an EMG in February, 2010 was due to radiculopathy. She admitted she had treatment for her prior back injury in February, 2003 which consisted of physical therapy and a couple of days off.

She did not remember having a WC case in 1998 while working for Athena Industries. She did not remember working for Tandem Tempo.

She did not remember telling the doctor at the clinic the day after her August 11, 2010 accident that she had radiculopathy as she did not know what that was. She admitted she asked Dr. Dorning for Norco 10 as the pain medication which was only a 5 was not helping and she knew about Norco 10 from her sister who was taking it. She admitted the same day she asked for Norco Dr. Dorning released her to return to work without restrictions.

Petitioner agreed she was released to return to work by her own doctor, Dr. Shah, on November 10, 2010 and November 22, 2010 and admitted she returned to work and worked until the Christmas break. She was released from physical therapy as of January, 2011.

Petitioner admitted she received a certified letter from Dr. Singh in February, 2011 terminating his relationship with her as her drug test on February 14, 2011 was clear for narcotics despite the fact that on January 11, 2011, January 26, 2011 and February 14, 2011 she had been prescribed narcotics. She testified that the reason she believed her test was negative for the narcotics as she must not have taken the pain meds that day; although she told Dr. Singh she had been taking her medication as prescribed. After Dr. Singh terminated the relationship, she went to Dr. Cheema for pain management.

In June 2015, petitioner admitted she advised Joseph Belmonte, who performed a vocational assessment at the request of petitioner's attorney, that she had her son's Norco with her, but claimed she had not taken any.

She admitted she has smoked for 5 to 20 years, but now only smokes seven to eight cigarettes a day. She testified that on the day of hearing she had only smoked one cigarette. She continues to smoke even though Dr. Shah, Dr. Cheema and Dr. Templin advised her to quit. She claims she has slowed down.

She admitted she went to Dr. Templin in July, 2011 and on May 19, 2015 she advised Dr. Templin she was doing well and was happy with her progress. She rated her pain at two or three out of ten.

On August 4, 2015, when she went to the emergency room at St. Joseph Hospital she did not know why she had her abdomen and pelvis tested. She received an injection in her arm.

She claimed she did not know what affect her working would have on her social security disability. She didn't have any call backs from her job applications.

Petitioner introduced the records of Meridian Medical Associates (PX.12). Petitioner was initially seen at Meridian Medical Associates on October 31, 2003 due to a work accident which occurred on October 29, 2003 while petitioner was working for respondent. She claimed to have injured her back while lifting and dumping a bucket of water. She was treated with physical therapy, Naproxen and Flexeril. She was discharged from treatment on November 5, 2003, with the suggestion she seek a second opinion as she seemed to disagree with Dr. Papaeliou's treatment.

According to the records, she was next seen by Dr. Papaeliou on July 20, 2004 due to right thumb tendonitis and possible carpal tunnel syndrome. She was also seen by Dr. Papaeliou was in August, 2006 due to a work-related hand laceration.

The Meridian Medical Associates records reflect the next time she was seen by Dr. Papaeliou was on August 12, 2010 for a lumbar strain. Petitioner related the pain in her right lumbar region to lifting stacks of chairs. She exhibited pain behavior. Her exam was negative. She was prescribed Vicodin and Flexeril, kept off work and advised to return on August 16, 2010. (PX.12, p.12)

On August 16, 2010, petitioner returned to Dr. Papaeliou with increased complaints of pain and paresthesia radiating into the posterior left calf. An MRI was ordered. She was kept off work and referred to orthopedic doctor, Dr. Dorning (PX12, p.10).

She saw Dr. Dorning on September 9, 2010 after obtaining an MRI on August 30, 2010. Dr. Dorning's diagnosis was lumbar myositis with L5-S1 spondylosis. Physical therapy and Ultracet was prescribed. She was to remain off work and return in a week and a half. (PX.12, p.7).

She returned to Dr. Dorning, having completed three sessions of physical therapy and discharged to home exercise program. She had called the week before seeking a prescription for Norco 10, which is what her sister was taking for her lung cancer. Dr. Dorning examination was negative. Dr. Dorning's diagnosis was L5-S1 spondylosis. Dr. Dorning released petitioner to return to work on September 27, 2010 without restrictions. (PX.12, p.4)

Petitioner introduced the records of her primary care doctor, Dr. Yatin Shah, of Primary Care of Joliet (PX.11 & PX.23).

The records contain a report of an EMG/NCV which had been completed on February 6, 2010. The history provided to Dr. Pandya, who performed the EMG on February 6, 2010, was: "Patient complains of low back pain radiating down the right leg." (PX.11, p.111)

Petitioner was first seen by Dr. Shah after the work accident on September 22, 2010. Petitioner reported she hurt herself at work on August 11, 2010 while lifting and moving chairs at school. Petitioner was requesting a second opinion and additional physical therapy. Dr. Shah reported the straight-leg raising was positive and petitioner had limited range of motion in the lumbar spine. Dr. Shah diagnosed intervertebral disc disorder with myelopathy of the lumber region. Norco 10 was prescribed (PX.11, pp.19-20).

On September 24, 2010 an EMG was ordered, which was completed by Dr. Pandya on September 27, 2010. The September 27, 2010 EMG was reported as normal. She was seen again by Dr. Shah on September 27, 2010 for acute bronchitis. Petitioner returned to Dr. Shah on October 12, 2010. She was again prescribed Norco 10. She began physical therapy on October 15, 2010. Petitioner reported to Dr. Shah on October 25, 2010 that she was improving with physical therapy. On November 2, 2010 and reported she had not returned to work as respondent did not have light duty. She requested a release to return to work without restrictions on November 8, 2010. On November 15, 2010 petitioner returned to Dr. Shah. She was in physical therapy and working at that time.

On November 16, 2010 petitioner was taken by ambulance from the school to St. Joseph Hospital The history recorded by the ER nurse was: "Patient states injured back six months ago. States reinjured back yesterday while cleaning house. Patient states having back spasms. Patient seen and assed by ED MD. Patient medicated and discharged to home…" (PX.8, part 1).

She followed up with Dr. Shah on November 17, 2010. She was released to return to work on November 18, 2010. On November 19, 2010, petitioner returned to Dr. Shah. Dr. Shah

reviewed the MRI again and extended physical therapy. Dr. Shah also was seeking approval to refer the petitioner to a plain clinic for an epidural steroid injection. Petitioner returned to Dr. Shah on December 3, 2010. Dr. Shah reported petitioner had approval for the referral to the pain clinic for epidural steroid injection; physical therapy was put on hold. On December 30, 2010 petitioner appeared at the Primary Care of Joliet requesting a refill of Norco as she was directed by Dr. Shah to return to the clinic for a refill. (PX.23)

On January 4, 2011, petitioner reported to Dr. Shah that she had a reoccurrence of her severe lower back pain. She claimed she was not able to work. She reported she was seen by "IME" and awaiting ESI approval. (PX. 11, p.89). She was kept off work due to severe low back pain (PX.23). She was seen again by Dr. Shah on January 7, 2011 and again kept off work due to low back pain (PX.11, pp.87, 43 & 23). She was seen on January 12, 2011 and was released to return to work on January 13, 2011 (PX. 11, p.85 & 44). She was discharged from physical therapy (PX.11, p.102). She was seen again by Dr. Shah on January 26, 2011 and reportedly awaiting approval for the pain clinic (PX.11, p.83).

On February 11, 2011, petitioner saw Dr. Shaw requesting a refill of pain meds and advised she was to see pain doctor the following Monday (PX.11, 81). She was taken off work due to a health condition (PX.11, 45).

On February 21, 2011, petitioner's pain doctor, Dr. Ranjeet Singh of Health Benefits Pain Management Services, reported petitioner had received a prescription of hydrocodone from Dr. Shah on January 26, 2011 and also February 11, 2011. Dr. Singh had prescribed Vicodin on February 14, 2011. Petitioner reported to Dr. Shah that she was actively taking her medication as prescribed and yet a random urine drug test done on February 14, 2011 showed no evidence of the medication. Dr. Singh therefore terminated his relationship with the petitioner for misusing her medication. (PX.11, p.101).

On February 25, 2011 petitioner saw Dr. Shaw with the same complaints and advising still at the pain clinic and off work (PX.11, p. 79). She returned to Dr. Shah on February 28, 2011 for a referral to another pain clinic (PX.11, 77). On March 9, 2011petitioner reported to Dr. Shah that she was waiting for an evaluation by the pain clinic (PX.11, p.75).

On March 10, 2011 petitioner was first evaluated by Dr. Asad Cheema of Holistic Science Pain Clinic, and an injection was performed and 60 Norco 10 was prescribed (PX.11, 95 & 96). Dr. Cheema provided matrix therapy, injections and prescribed 60 Norco every month from March, 2011 through July, 2011 (PX. 11 & PX.14). Petitioner was also being seen by Dr. Shah monthly during this same period of time (PX.11 & 23).

On July 19, 2011, petitioner was evaluated by Dr. Cary Templin of Hinsdale Orthopaedics. Dr. Templin reported petitioner's straight leg raising was negative, lumbar flexion at 65, she had increased pain on extension and minimal tenderness over the paraspinal musculature, SI joints and greater trochanteric region. Dr. Templin also noted a positive Waddell's sign. Dr. Templin diagnosed facet arthropathy at L5-S1 and aggravation of her preexisting condition due to her work-related injury. Dr. Templin recommended a facet block at the L5-S1 level and to return on an as needed basis. (PX.16, p.31)

On July 21, 2011, Dr. Cheema performed a right-sided facet joint injection. Dr. Cheema continued to perform matrix physical therapy and prescribed 60 Norco 10. On October 12, 2011, Dr. Cheema increased the Norco 10 prescription to 120. (PX.14)

Petitioner returned to Dr. Templin on November 8, 2011 with continuing back pain. Petitioner's exam was negative. Dr. Templin recommend petitioner discuss a discogram with Dr. Cheema. (PX.16, p.30)

Petitioner saw Dr. Cheema on November 14, 2011, who prescribed 120 Norco 10 and sent petitioner for another MRI of the lumbar spine (PX.14, p.23).

On November 17, 2011 petitioner was examined by Dr. Steven Mather of M & M Orthopaedics at the request of respondent. Dr. Mather examined the petitioner, reviewed various medical records and MRI and concluded petitioner had sustained a lumbar strain from the work accident that had resolved. Dr. Mather believed any ongoing problems or pain was related to the pre-existing degenerative disc disease. Dr. Mather believed petitioner should not be prescribed any further narcotics due to her drug-seeking behavior as evidence by her request of Dr. Dorning to prescribe Norco. (RX.1)

Dr. Mather discussed follow up treatment by a Dr. Udit Patel on December 28, 2010. He recommended an epidural steroid injection. Dr. Patel's examination was absent any objective findings per Dr. Mather's report. (RX.1)

Petitioner underwent a discogram and post discogram CT scan by Dr. Payvar on November 30, 2011 which showed a Grade IV radial tear at L5-S1 level and Grade I annular tear at the L4-5 level (PX.16, p. 59-60). At the time of discharge from Provena St. Joseph post discogram on November 30, 2011, Norco was prescribed (PX.8, part 2).

On December 6, 2011 Dr. Cheema prescribed 120 Norco 10 (PX.14, p.24).

On December 16, 2011, petitioner became dizzy while driving and run up on the sidewalk. She was treated at Silver Cross Hospital. She obtained a Doppler of the carotid artery, CT scan and MRI of the brain. (PX.23) She followed up with Dr. Shah on December 30, 2011 for the high blood pressure (PX.11, p.59).

She returned to Dr. Templin on January 17, 2012 and March 30, 2012 and surgery was discussed and then scheduled for April 4, 2012 (PX.16, pp.27-30).

Between February 2, 2012 through March 5, 2014, Dr. Cheema prescribed both Percocet and Norco up to 120 tablets of each every 30 days (PX.14, pp.26-53). As of April 2, 2014, the prescriptions were reduced to 120 tablets of Percocet by Dr. Cheema (PX.14, pp.54-66).

Petitioner underwent a fusion by Dr. Templin at Joseph Hospital by Dr. Templin on April 4, 2012 (PX.16, p.47). She followed up with Dr. Templin on July 3, 2012, October 12, 2012, December 4, 2012 and January 5, 2013 (PX.16, pp.17-23).

Petitioner received physical therapy from Pirie Chiropractic & Elite Rehabilitation Institute from July 2012 until January, 2014 (PX.6).

On April 24, 2013, the day before petitioner's surgery, Dr. Cheema prescribed 90 Percocet, 120 Norco and 21 Oxycontin for post-operative pain (PX.14, p.43).

Due to a non-union, Dr. Templin had to redo the fusion on April 25, 2013 (PX.16. p, 37). At the time of discharge from the hospital on April 25, 2013, Dr. Templin prescribed Norco 10 (PX.8, part 2).

Petitioner followed up with Dr. Templin on June 17, 2013, July 20, 2013, October 29, 2013, January 28, 2014 and March 11, 2014 (PX. 16, pp. 8-15).

Dr. Steven Mather testified in behalf of respondent via deposition on December 20, 2013 (RX.2). Dr. Mather had examined petitioner at respondent's request on November 17, 2011 (RX.2, p.6). Petitioner reported to Dr. Mather that she had complaints of pain in the right lower back that traveled into the right hip and went down the right leg (RX.2, p.7). Dr. Mather's examination was normal except for mild scoliosis, or curvature of the spine (RX.2, p.8). Dr. Mather's review of the X-ray showed some arthritic changes of the right L5-S1 facet joint (RX.2, p.9). Dr. Mather reviewed the petitioner's medical records and the MRI from August 31, 2010 (RX.2, p.10). The MRI showed one nerve root compression that showed old degenerative changes at L1-2 and also the right L5-S1 facet joint without acute findings (RX.2, p.10).

Dr. Mather concluded, based upon his examination of the petitioner, the records and the film studies, the petitioner's August 11, 2010 injury was a lumbar strain for which petitioner was able to return to work on September 22, 2010 (RX.2, p.11). Dr. Mather did not believe the lifting accident of August 11, 2010 aggravated petitioner's pre-existing degenerative problems in her spine (RX.2, p.12). Dr. Mather did not believe there was a medical indication for the fusion or the redo of the fusion; nor did Dr. Mather believe the fusions were related to the work accident (RX.2, p.13). Dr. Mather did not find any objective evidence of an acute injury or aggravation of petitioner's degenerative condition (RX.2, pp.20-21).

On May 20, 2014, petitioner reported her pain to Dr. Templin at between 1 or 2 out of 10. She was doing well. Dr. Templin asked petitioner to follow up in one year. (PX16, pp.5-6)

Dr. Templin testified for the petitioner on December 5, 2014 via deposition (PX.1). Dr. Templin initially saw petitioner on July 19, 2011. Petitioner provided a history of the work accident consistent with her testimony (PX.1, pp.6-7). Dr. Templin reviewed X-rays and an MRI (PX.1, pp.7-8). Dr. Templin reported the MRI showed mild degenerative changes with significant arthritis in the facet joints at L5-S1, a transitional vertebra below that, but no severe stenosis (PX.1, p.8). Dr. Templin knew petitioner had epidural injection, but recommended a facet joint injection (PX.1, p.8). His diagnosis at the initial visit was facet arthropathy (PX.1, p.9). Dr. Templin believed that because of the timing of the pain, her work accident, it was caused by the work accident (PX.1, p.10).

The petitioner returned to Dr. Templin on November 8, 2011 and reportedly was not doing any better (PX.1, p.11). Dr. Templin believed the MRI showed a degenerative condition rather than acute (PX.1, p.11). Dr. Templin concluded that because petitioner had only minimal, temporary relief from the facet blocks, petitioner should proceed with a discogram (PX.1, p12).

Petitioner returned to Dr. Templin on January 17, 2012, having completed the discogram (PX.1, pp.12-13). Dr. Templin reported the CT portion showed a grade four annular tear at L5-S1 and the provocative portion of the discogram showed she had concordant pain at the same level (PX.1, p.13). Dr. Templin testified that the annular tear could be degenerative or from trauma (PX.1, pp.13-14). Dr. Templin could not tell how long the tear had been there or whether it was directly caused by the work accident of August 11, 2010 (PX.1, p.14).

Dr. Templin concluded, based upon the discogram findings, petitioner's ongoing complaints and the fact petitioner had extensive non-operative treatment without relief, a fusion at the L5-S1 level was appropriate (PX.1, pp.14-15). Dr. Templin believed the need for the fusion was needed because of the work accident as petitioner's complaints began after the lifting incident (PX.1, p.16).

On April 4, 2012, Dr. Templin performed L5-S1 fusion (PX.1, p.17). On July 3, 2012, Dr. Templin ordered physical therapy (PX.1, pp.18-19). On October 2, 2012, Dr. Templin noted petitioner was to start work conditioning (PX.1, p.19). At the December 4, 2012 visit, petitioner reported increased pain; a CT scan was ordered (PX.1, pp.19-20). On January 29, 2013, Dr. Templin concluded that removal of the hardware and re-fusion was appropriate due to loosening of the S1 screws (PX.1, p.21).

On April 25, 2013, Dr. Templin performed another surgery to petitioner's back, which was to remove the hardware redo the fusion (PX.1, p.22). On July 30, 2013, Dr. Templin initially was going to start physical therapy, but did not. Dr. Templin released petitioner to return to work with a five-pound weight-lifting restriction (PX.1, pp.23-24). Physical therapy was started on October 29, 2013 (PX.1, p.24).

On March 11, 2014, Dr. Templin reviewed the CT scan which showed there was some evidence of screw loosening, but believed petitioner was fusing (PX.1, p.25). He believed she was slow fusing which Dr. Templin attributed to poor bone quality and the fact petitioner continued to smoke, despite being admonished to stop (PX.1, p.25). Dr. Templin also attributed the slow fusing to his inability to sue BMP (a chemical that helps bone form) due to petitioner's breast cancer (PX.1, pp.25-26).

The last time petitioner saw Dr. Templin before his deposition was May 20, 2014 (PX.1, p. 26). X-rays were taken and showed everything was in line (PX.1, pp.27-27). Dr. Templin released her to return to work with a ten-pound weight-lifting restriction and advised petitioner to return in a year (PX.1, p.27).

Dr. Templin final diagnosis was degenerative disc disease, facet arthropathy and low back pain (PX.1, p.28). Dr. Templin believed the condition was aggravated by the work accident (PX.1, p.28). Dr. Templin believed the treatment rendered by him to petitioner was the result of

the work accident (PX.1, p.29). Dr. Templin also believe the weight-lifting restriction of ten pounds was the result of the work accident (PX.1, pp.29-30).

On cross-examination, Dr. Templin testified that there is a higher risk of non-union in patients who smoke (PX.1, p.34). Dr. Templin confirmed that he thought the primary cause of her lack of fusion was due to the fact that petitioner continued to smoke (PX.1, p.35). Dr. Templin was unaware that petitioner had been released in September and again in November, 2010 to return to work without restrictions (PX.1, p.38). Dr. Templin agreed petitioner had one positive Waddell sign, which is indicative of symptom magnification, at the time of his first exam of petitioner on July 19, 2011 (PX.1, p.39).

Dr. Templin was unaware that petitioner had been in an automobile accident in December, 2011 (PX.1, pp.40). He did not believe petitioner's condition had changed from before or after the accident (PX.1, pp.40-41). Dr. Templin confirmed that in response to a letter in November, 2013, he thought petitioner could return to light to medium physical demand (PX.1, p.42). Dr. Templin agreed a discogram was highly subjective (PX.1, p.48).

Petitioner was re-evaluated by Dr. Mather at the request of respondent on February 26, 2015. Dr. Mather found petitioner had a solid fusion and was capable of returning to work at her usual employment with respondent. Dr. Mather did not believe the fusion or the re-fusion was necessitated by the work accident. Dr. Mather based this opinion on the mechanics of the claimed accident, indicating facet arthropathy would not be aggravated by lifting chairs. (RX.3)

On May 19, 2015, petitioner returned to Dr. Templin. She reported her pain at between 2 and 3. She was doing well. (PX.16, pp.4b-4c)

On June 5, 2015, petitioner was evaluated by vocational counselor, Mr. Joseph Belmonte, of Vocamotive, at the request of petitioner's attorney. Petitioner provided Mr. Belmonte with a detailed history of her injury and treatment. Oddly, petitioner produced a bottle of Ibuprofen 800 mg that also contained Oxycodone pills, which petitioner advised was her son's. Mr. Belmonte reported that both petitioner and her husband had a prescription for Oxycodone. Petitioner advised Mr. Belmonte that she took 3-4 Oxycodone a day. Although petitioner reported she had a car and driver's license, she did not like to drive when she was taking Oxycodone. (PX.21)

Petitioners advised Mr. Belmonte that she was released by Dr. Templin to return to work with a ten-pound weight-lifting restriction, but she believed she could only lift five pounds. She reported a sitting tolerance of 30 minutes, standing tolerance of 10 minutes and ability to walk a half of a mile. (PX.21)

Mr. Belmonte strongly recommended vocational testing and a comprehensive evaluation given petitioner's limited education and limited work experience. Mr. Belmonte identified elements of acquired disability/vocational handicap, which were: significant inappropriate language syntax; physical limitations; work experience; and the use of Oxycontin. Based upon these factors, Mr. Belmonte believed petitioner's possibility of becoming employed was very low. (PX.21)

Respondent obtained a vocational assessment on September 2, 2015 by Ms. Julie Bose of MedVoc Rehabilitation. Petitioner provided a detailed medical and vocational history to Ms. Bose. Petitioner advised Ms. Bose that she had been searching for any type of job for the past two years (See PX. 18 and PX.24). (RX.7)

Petitioner advised Ms. Bose she was taking Vicodin four times a day without any adverse effect. Ms. Bose opined that petitioner would be capable of earning $12.00 per hour considering the ten-pound weight-lifting restriction per Dr. Templin. (RX.7)

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator does not find the petitioner to be credible. Petitioner's credibility was called into question based upon her drug-seeking propensity and her continued ability to obtain multiple prescriptions of narcotics with only minimal complaints of pain and the lack of objective findings to support her minimal subjective complaints.

The factors taken into consideration by the Arbitrator in judging petitioner's credibility were:

1. Within a month after her claimed work injury, petitioner was seeking a prescription for Norco, from the company clinic physician, Dr. Dorning. Petitioner claimed she wanted the stronger prescription of Norco 10, which was what her sister was being prescribed for lung cancer, as the other medication was not strong enough to stop the pain. On September 22, 2010, when Dr. Dorning did not prescribe this medication and instead released petitioner to return to work, petitioner sought and obtained treatment and a prescription for Norco from her own physician, Dr. Shah.

2. Four months later, after petitioner received three narcotic prescriptions in a week's time, her urine drug test was clean for said prescriptions. Due petitioner's apparent misuse of the narcotics, petitioner's pain doctor, Dr. Singh, terminated the patient doctor relationship. Although Dr. Singh's records reported petitioner was using the medication as prescribed, petitioner testified she must not have been taking the medication as she was trying to cut back.

3. At the time of petitioner's evaluation by Joseph Belmonter, her own vocational expert, petitioner admitted she was in the possession of her son's Oxycontin even though both she and her husband had their own prescription for Oxycontin.

4. Petitioner successfully obtained an inordinate amount of Norco, Percocet and other narcotics on a monthly basis form her pain doctor. At times, she simultaneously obtained narcotics from Dr. Templin, Dr. Shah and hospital emergency rooms.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following finding:

The Arbitrator finds petitioner's present back condition for which petitioner obtained two fusions was not caused by the work accident of August 11, 2010. The only condition caused by the work accident was a lumbar strain that had resolved by the time petitioner returned to work in November, 2010.

The Arbitrator basis this finding on the opinion of Dr. Steven Mather, as well as all the medical evidence that did not support petitioner's ongoing complaints of pain. As petitioner's credibility was called into question, her complaints of pain are questionable; they were not substantiated by any objective findings of an ongoing problem from the work injury.

The Arbitrator makes this determination despite the testimony of petitioner's orthopedic surgeon, Dr. Cary Templin. Dr. Templin did not have any of petitioner's prior medical records when he opined that petitioner's back injury, which resulted in the fusion and re-fusion, was necessitated by the claimed lifting work accident of August 11, 2010. Dr. Templin based his opinion that the work accident aggravated the petitioner's degenerative disc disease and facet arthropathy because petitioner's complaints of back pain started after her lifting accident at work on August 11, 2010.

Dr. Templin presumed petitioner had been truthful when she stated the pain began only after the lifting incident at work, without being aware petitioner had similar complaints of pain in her lower back for which she sought treatment in February, 2010 and without being aware of petitioner's motivation to complain of back pain in order to obtain narcotics. Additionally, Dr. Templin could not tell how long the annular tear had been there or if it was caused by the accident.

Furthermore, Dr. Templin was not aware that petitioner had returned to work in November, 2010 and then claimed on November 16, 2010 when she was taken by ambulance to St. Joseph Hospital and provided a history she reinjured back yesterday while cleaning house.

Finally, Dr. Templin agreed that at the time of his initial evaluation of petitioner that she had a positive Waddell's sign which is indicative of symptom magnification.

As Dr. Templin's opinion as to causation relies on the credibility of petitioner's statements to him and as petitioner's credibility has been called into question, the Arbitrator discounts the testimony of Dr. Templin on this issue.

For these reasons, the Arbitrator finds petitioner failed to prove by a preponderance of the evidence that her ongoing back problems, which resulted in two back surgeries, were caused by the work accident of August 11, 2010.

As the Arbitrator did not find the initial fusion was not necessitated by the work injury, whether the need for a redo of the fusion was caused by the petitioner's smoking, is moot.

In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The Arbitrator, finding petitioner failed to prove that any ongoing problems after November 15, 2010 were caused by the work accident, denies any claimed medical costs after November 15, 2010.

In support of the Arbitrator's decision with regard to temporary benefits, the Arbitrator finds the following:

Petitioner was off work under the direction of the company doctors at Meridian Medical Associates until September 27, 2010. Thereafter, petitioner was kept off work until November 3, 2010. Petitioner was released to return to work as of November 4, 2010 and worked until the Christmas break in 2010. The Arbitrator finds that petitioner, by her own admission, sustained re-injury on November 15, 2010 while cleaning house. There was no objective evidence to support petitioner's disability after she returned to work in November, 2010.

Accordingly, the Arbitrator awards temporary total disability from August 12, 2010 through November 3, 2010, which is 12 weeks @$616.53 per week.

In support of the Arbitrator's decision with regard to the nature and extent of injury, including whether petitioner is permanently and totally disabled, the Arbitrator finds the following:

Petitioner claims she is permanently totally disabled under theory of "odd-lot" permanent total disability. Petitioner relies upon her purported two-year job search efforts and the opinion of vocational counselor, Joseph Belmonte. However, Mr. Belmonte's opinion was equivocal; falling short of determining petitioner was permanently and totally disabled.

Furthermore, petitioner was able to work from her return to work in November, 2010 until Christmas break, 2010. Petitioner did not prove she was disabled after her return to work on November 4, 2010 for the reasons already stated.

Petitioner also failed to prove that petitioner's back injury caused by work accident was so severe as to necessitate the fusion and subsequent re-fusion. The evidence supports a finding petitioner sustained a lumbar strain. Based on this finding, the Arbitrator awards petitioner 10% person as a whole pursuant to §8 (d) 2 of the Act.

In support of the Arbitrator's decision with regard to penalties and attorneys' fees, the Arbitrator finds the following:

The Arbitrator finds respondent relied upon credible evidenced to deny temporary total disability and medical benefits. Therefore, the Arbitrator denies penalties and attorneys' fees.

In support of the Arbitrator's decision with regard to the issue of whether petitioner exceeded her choice of doctors pursuant to §8 a, the Arbitrator finds the following:

Petitioner did not exceed her choice of two doctors in violation of §8a. Petitioner initially received treatment from Meridian Medical Associates, where she had been directed to go by respondent. Thereafter, she began treatment with her primary care doctor, Dr. Shah. Dr. Shah referred petitioner to Dr. Singh. After Dr. Singh terminated the patient/physician relationship, petitioner returned to Dr. Shah and was referred to Dr. Cheema. Dr. Cheema referred petitioner to Dr. Templin. Treatment received at the emergency rooms was due to claimed emergency. Therefore, the Arbitrator finds petitioner did not exceed her two choices of doctors, but rather only used one choice that began with Dr. Shah.

STATE OF ILLINOIS)
)
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

Allen Miller,
Petitioner,

vs.

No: 15 WC 31281

18IWCC0592

Advance Services, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) has been filed by Respondent herein and notice given to all parties. The Commission, after considering issues including accident, causal connection, medical expenses, and prospective care and being advised of the facts and law, modifies the Decision of the Arbitrator by vacating the award of §19(k) penalties and §16 fees. The Commission otherwise affirms and adopts the Decision of the Arbitrator, a copy of which is attached hereto and made a part hereof. The Commission 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 (1980).

The Arbitrator's decision was filed on January 25, 2017, following §19(b) hearing held on September 19, 2016. The Arbitrator found that Petitioner, a 36-year-old general laborer, proved a work-related accident sustained on September 17, 2016, when his left wrist was injured during a forklift collision. Petitioner was terminated from employment later that day for an unrelated reason. The Arbitrator awarded Petitioner temporary total disability compensation under §8(b) and medical expenses, including prospective care, under §8(a).

Up through the date of hearing, Respondent had denied liability and made no payment of any benefits. The Arbitrator found Respondent's asserted grounds for denial of liability unreasonable. In addition to the aforementioned benefits, the Arbitrator awarded §19(k) penalties (totaling $1,410.64) and §16 attorney's fees (totaling $564.26). However, the Arbitrator declined to impose penalties under §19(l). Section 19(l) provides, in pertinent part:

> If the employee has made a written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and 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[.]

820 ILCS 305/19(l). Regarding his decision not to impose §19(l) penalties, the Arbitrator wrote that "the record in this matter does not reflect when payment for benefits was demanded, or when Petitioner first provided Respondent with documentation of work status." The Arbitrator also cited the Respondent's representation that it was provided with Petitioner's medical bills for the first time on the date of hearing, when Petitioner submitted the bills into evidence.

With respect to the demand for payment requirement of §19(l), the Appellate Court has held that the "act of submitting medical bills into evidence during arbitration is not the same as tendering them to the employer for payment." *Theis v. Illinois Workers' Comp. Comm'n*, 2017 IL App (1st) 161237WC, 2017 Ill. App. LEXIS 145, 9 (Commission's award of §19(l) penalties was against the manifest weight of the evidence, because the employer provided adequate justification for its delay in paying claimant's award of medical expenses due to claimant's failure to timely tender her medical bills to the employer). Given that Petitioner failed to provide the medical bills until the hearing date, Respondent provided adequate justification for its delay of payment of the medical bills.

As for the award of penalties as it relates to Respondent's failure to tender payment of temporary total disability benefits, Respondent relied on Section 11 of the Act and its interpretation of the same as its basis for denial of payment. "The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified." *Jacobo v. Illinois Workers' Compensation Commission*, 2011 IL App (3d) 100807WC, ¶ 19. Although we find Respondent's interpretation of Section 11 of the Act to be misguided which we will discuss in more detail below, such reliance was not unreasonable.

The Supreme Court of Illinois articulated the standards for the imposition of penalties under the Act two decades ago in *McMahan v. Industrial Commission*:

> Viewing the statue as a whole, we believe that section 19(k) and section 19 (l) were actually intended to address different situations. The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." If the payment is late for whatever reason,

> and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory.
>
> In contrast to section 19(l), section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory. See *Smith v. Industrial Comm'n 170 Ill. App. 3d 626, 632, 121 Ill. Dec. 275, 525 N.E.2d 81 (1988)*. The statute is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statue's use of the terms "vexatious," "intentional" and "merely frivolous." Section 16, which uses identical language, was intended to apply in the same circumstances. *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 515, 702 N.E. 2d 545 (1998).

Section 19(k) penalties and Section 16 attorneys' fees require a higher standard of proof in that the delay in payment must not only be unreasonable but must be "deliberate or the result of bad faith or improper purpose." *McMahan* at 515. As the Commission finds Respondent's delay in payment was reasonable, it follows Section 19(k) penalties and Section 16 attorneys' fees are not applicable. The Commission vacates the award of penalties pursuant to Section 19(k) and attorneys' fees pursuant to Section 16.

Respondent in disputing payment of compensation relied on a novel interpretation of Section 11 of the Act. Section 11 states, in part,

> If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath, or urine or if there is any evidence of impairment due to the unlawful or unauthorized use of (1) cannabis as defined by the Cannabis Control Act, (2) a controlled substance listed in the Illinois Controlled Substances Act, or (3) an intoxicating compound listed in the Use of Intoxicating Compounds Act or if the employee refuses to submit to testing of blood, breath, or urine, then there shall be a rebuttable presumption that the employee was intoxicated and the intoxication was the proximate cause of the employee's injury.

820 ILCS 305/11 (West 2013). Respondent posits "the time of the accidental injuries" should be interpreted to mean "the time notice is provided" of the accidental injury as opposed to the actual date of the occurrence of the accident. We disagree.

As Respondent argued in its brief, "The cardinal rule of statutory construction is to ascertain and give effect to the intent of the legislature. *Cassens Transport Co., 218 Ill. 2d at 524.* The best indicator of the legislature's intent is the language of the statue itself, which must be given its plain and ordinary meaning. *Will Count Forest Preserve District v. Illinois Workers' Compensation Comm'n, 2012 IL App (3d) 110077WC, ¶ 18.* Moreover, '[w]e must construe the statute so that each work, clause, and sentence is given a reasonable meaning and not rendered superfluous, avoiding an interpretation that would render any portion of the statute meaningless or void.' *Cassens Transport Co., 218 Ill. 2d at 524.*" *Respondent's Statement of Exceptions and Brief on Review*, p. 5. Additionally, "[w]e also presume that the General Assembly did not intend, absurdity, inconvenience, or injustice. [Citation omitted]." *Sylvester v. Industrial Commission*, 197 Ill. 2d 225, 232, 756 N.E.2d 822 (2001). The plain and ordinary meaning of "at the time of the accidental injuries" means at the time the accidental injuries

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occurred. If the legislature had intended "at the time of the accidental injuries" to mean notice of the accident, they could have written the statute accordingly. They did not. Additionally, interpreting the statute as requested by Respondent would potentially lead to an absurd, inconvenient, or unjust result. Under Section 6 (c) of the Act, an employee has 45 days in which to report his injury. Therefore, any employee who reported an accident within the statutory time frame could be denied compensation based solely on a request from an employer to submit to an alcohol/drug screening which would have little or no probative value as to the employee's physical state at the time of the accident.

Moreover, in the present matter, Petitioner testified he notified a representative of Respondent on September 18, 2015 (T. 22), yet Respondent waited until September 24, 2015 to request an alcohol/drug screening which Petitioner asserted he was willing to attend once he obtained transportation. T. 39. Even if we were to construe the Act as requested by Respondent, Petitioner did not wholly refuse to submit to an alcohol/drug screening.

As noted above, we find the Respondent's position lacking in merit, as well as being expansive in its creativity, but not so legally unreasonable as to warrant imposition of penalties for vexatious conduct. Accordingly, the penalties and fees awarded by the Arbitrator are vacated. All other findings and awards of the Arbitrator are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Commission modifying in part and affirming in part the Decision of the Arbitrator filed January 25, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980), but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: SEP 28 2018

Joshua D. Luskin

Charles J. DeVriendt

Elizabeth Coppoletti

o-07/31/18
jdl/ac
68

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

MILLER, ALLEN
Employee/Petitioner

Case# **15WC031281**

ADVANCE SERVICES INC
Employer/Respondent

18IWCC0592

On 1/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2965 KEEFE CAMPBELL BIERY & ASSOC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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)

Allen Miller
Employee/Petitioner

v.

Advance Services, Inc.
Employer/Respondent

Case # **15** WC **31281**

Consolidated cases: **N/A**

18IWCC0592

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 **Peoria**, on **9/18/16**. 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 **Section 11, Intoxication**

FINDINGS

On the date of accident, **9/17/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner did not work a full 52 weeks; the average weekly wage was **$463.25**.

On the date of accident, Petitioner was **39** 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

Respondent shall pay reasonable and necessary medical services of $60,024.77, as set forth in Petitioner's exhibit 8, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $303.83/week for 48 4/7 weeks, commencing 9/19/15 through 11/23/15 (9 2/7 weeks), and 12/17/15 through 9/18/16(39 2/7 weeks), as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Blair Rhode, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner penalties of **$564.26**, as provided in Section 16 of the Act; **$1,410.64**, as provided in Section 19(k) of the Act; and **$0**, as provided in Section 19(l) of the Act.

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

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

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

Michael K. Nowak, Arbitrator

12/28/16
Date

ICArbDec19(b)

JAN 25 2017

FINDINGS OF FACT

Petitioner testified that he began working for Advance Services Inc., a staffing agency, sometime in June of 2015. Petitioner testified that he was working at Syngenta through Advance Service Inc. Petitioner testified that his job title was that of a Forklift Operator. Petitioner briefly testified at to his job description. Petitioner testified that his job required him to clean out "Qbits," paint, clean out grain bins, lift the Qbits with a forklift and drive the forklift. A photograph of a Qbit was offered into evidence as Petitioner's Exhibit 9A.

Petitioner testified that on September 17, 2015, towards the end of his shift, he was cleaning and scraping a label from a Qbit. He indicated that since it was near the end of the shift everybody was in a rush to move the Qbits to the warehouse. Petitioner testified that he was in a standing position scrapping the Qbit with a putty knife. He testified that there were two Qbits on rollers which had been cleaned near him waiting to be picked up and moved. As Petitioner was scraping the label from a Qbit, a forklift operator came to pick up the cleaned Qbits. Petitioner testified that the forklift operator did not honk or otherwise warn of his presence. Petitioner testified that the Forklift operator missed the pickup point and pushed the two Qbits toward him striking him on the left arm jamming his left arm and flexed wrist in between the Qbit Petitioner was scrapping. Petitioner testified that immediately he felt pain in his arm and in his wrist. On cross examination Petitioner testified that neither his arm or hand were "smashed" between the Qbits, but rather the Qbits came from behind and pushed his left arm and hand into the Qbit Petitioner was scrapping. On the day of the accident, Petitioner was unable to fill out an incident report as his supervisor, Brett, was gone for the day. Petitioner testified that the next morning he reported the incident to Brett. Petitioner further indicated that later that day he and another employee became involved in a verbal altercation which resulted in Brett firing him at the end of the day.

The Arbitrator notes that the Respondent did not offer any evidence to rebut Petitioner's testimony regarding accident and notice, and did not dispute notice on the Request for Hearing form. The Arbitrator further notes that Petitioner's Exhibit 2, a statement of the incident authored by the Petitioner and dated September 28, 2015, was entered and admitted into evidence without objection. This statement of accident is consistent with Petitioner's testimony.

On September 18, 2015 Petitioner presented to OSF emergency department. (PX3) Petitioner presented with complaints of left hand and wrist pain. The notes of the OSF emergency room physician, Rose Marie Haisler, D.O., indicate "Patient at work yesterday and a forklift driver caught his left hand and wrist between 2 boxes has had pain on the radial aspect of his left forearm hand since." (PX3, Pg. 006). Her notes further indicate that "[t]he incident occurred yesterday. The incident occurred at work. The injury mechanism was compression (hand crushed between 2 boxes AP compression and a little axial) the pain is present in the left wrist and left hand. The quality of pain is described as aching. The pain is moderate. The pain has been constant since the incident". (*Id.*, at 007) Petitioner was diagnosed with closed nondisplaced fracture of scaphoid bone of left wrist and referred to Dr. Garst at Great Plain Orthopedics for an orthopedic referral. (*Id.*, at 009-011)

Petitioner testified that at Great Plain Orthopedics he was seen by Dr. Anane-Sefah. Petitioner first presented to Great Plains on September 22, 2015. The history noted by Dr. Anane-Sefah indicates that Petitioner:

> [S]ustained an injury to his left upper extremity at work when he states that, 'there were a lot of cubits being put down with a roller.' He states that one of these large things was pushed and his arm was caught in between and hit the posterior aspect of his elbow pushing the right[sic] wrist into forceful flexion, injuring the upper extremity. He states that this was a crushing-type injury with the force directed from posterior at the posterior aspect of his elbow and wrist was forced down onto another hard object. He noted immediate pain and swelling and some paresthesia in the left upper extremity.

(PX5 Pg. 010). After proceeding with a Physical examination and reviewing radiographs that were obtained on September 18, 2015 at OSF, Dr. Anane-Sefah diagnosed the Petitioner with left elbow contusion, left forearm contusion and left wrist contusion with concern for occult scaphoid fracture and possible occult distal radius fracture and distal ulnar fracture. Petitioner was placed into a thumb spica cast and was provided with an off work note. (*Id.*, at 011)

Petitioner testified that on September 24, 2015 his supervisor contacted him to come to the facility for a drug test. Petitioner testified that he advised his supervisor that his attorney had advised him to not go back on the employer's property. Petitioner testified that his supervisor called him again on September 28, 2015 regarding a drug test. Petitioner testified that at that time he was out of town at a funeral. Petitioner testified that the next day on September 29, 2015, his supervisor called him again regarding going for a drug test, but at that time Petitioner did not have any transportation. Petitioner indicated that his Supervisor was to arrange for transportation and call Petitioner back. Petitioner testified that he never heard from the supervisor again. Petitioner testified that he never refused to undergo a drug test. Most significantly, Petitioner testified that he was never asked to take a drug test while he was still employed by Respondent. The Arbitrator notes that Respondent did not offer any evidence to rebut Petitioner's testimony regarding the drug test issue. [1]

Petitioner followed up with Great Plains on October 5, 2015. Dr. Anane-Sefah, after reviewing the X-rays taken that day, diagnosed Petitioner with left wrist contusion and a minimally nondisplaced left scaphoid wrist fracture. During this visit, Petitioner was place back into a thumb spica. Petitioner was noted to be experiencing pain in Left wrist and Left elbow. (*Id.*, at 009) Petitioner next followed up with Great Plains on November 2, 2015 complaining of a lot of pain in the wrist. During this visit, Dr. Anane-Sefah placed Petitioner back into a thumb spica and ordered MRI of left wrist. (*Id.*, at 005) The MRI of Petitioner's Left wrist was taken at OSF on November 20, 2015, and revealed a carpal bone cyst in the scaphoid measuring 7mm. The MRI also reveal increased signal in the volar membranous portion of scapholunate ligament. (PX4, Pg.002)

After the MRI, Petitioner followed up with Dr. Anane-Sefah on November 23, 2015. At this time, Dr. Anane-Sefah diagnosed Petitioner with left wrist pain, healed nondisplaced left scaphoid fracture, and left wrist, forearm, and elbow contusion, resolved. Formal therapy was contemplated, but Petitioner requested he be allowed to work without restrictions. Petitioner was therefore released to go back to work without restrictions, to follow up on as needed basis.

[1] The Arbitrator notes that the examination performed by Dr. Haisler in the emergency room on September 18, 2015 indicates Petitioner was "alert and oriented to person, place, and time." PX3, Pg. 006

Petitioner testified that after being discharged from Dr. Anane-Sefah, he saw Dr. Rhode. Petitioner testified that he was not happy with the treatment offered by Dr. Anane-Sefah. Petitioner testified that he has had prior carpal tunnel surgery by Dr. Rhode. Petitioner first saw Dr. Rhode 's office on December 17, 2015 and was evaluated by Dr. Rhode's P.A., Lori Welke. Ms. Welke noted that Petitioner "presents with a left wrist injury from Sept 17, 2015. This occurred as he was employed with Sygenta in Pekin, IL. He was cleaning and scraping off stickers from 400 pound tubs when a forklift slid on wet ground hitting the tubs which forcefully ran into Mr. Miller's posterior left elbow as he was scraping with a putty knife. His wrist jammed into the tub and he had immediate pain." (PX6, Pg. 2) It is also noted that Petitioner stopped treating with Great Plains because he didn't feel he was getting the right care and was still having pain. (*Id.*) Physical therapy was recommended and Petitioner was placed on modified duty. (*Id.*, at 3)

Petitioner underwent Physical therapy from December 18, 2015 to January 7, 2016. Petitioner then saw Dr. Rhode on January 13, 2016. Dr. Rhode at this time recommended that patient continue physical therapy. Petitioner continued physical therapy form January 13 to February 10, 2016. Petitioner next followed up with Dr. Rhode on February 10, 2016. At that time it was noted that the Petitioner continued to have radial sided wrist pain. Based on the positive Finkelstein's maneuver, Dr. Rhode diagnosed Petitioner with de Quervain's tenosynovitis and administered a de Quervain's injection and physical therapy was continued. (PX6, Pg. 35) Petitioner next followed up with Dr. Rhode on February 24, 2016. At this time Dr. Rhode noted that Petitioner experienced temporary relief from the injection. After noting failed conservative care, Dr. Rhode recommended surgery. (*Id.*, at 42-44) Thereafter Petitioner continued to follow up with Dr. Rhode, and Dr. Rhode continued to seek authorization for a de Quervain's release. (*Id.*, at 45-68)

On July 26, 2016, Petitioner underwent a left open de Quervain's release. (PX7)

Post Operatively, Petitioner followed up with Dr. Rhode on August 24, 2016. At that time Petitioner was experiencing mild numbness in the distribution of sensory branch of the radial never. (PX6, Pg. 72) Before the hearing, Petitioner last followed up with Dr. Rhode on September 7, 2016. At that time Petitioner continued to experience mild numbness in the distribution of sensory branch of the radial never.(*Id.*, at 75) Petitioner's work status at that time was off duty. (*Id.*, at 77)

Dr. Rhode's deposition was taken at the request of Respondent on August 22, 2016. (RX4) Dr. Rhode testified that he diagnosed Petitioner with de Quervain's tenosynovitis. (*Id.*, at 11) Dr. Rhode opined that "the patient's radially based pain, which I believe at the time we evaluated it represented de Quervain's tenosynovitis, was causally connected to the injury and/or the management of the injury". (*Id.*, at 12-13) Dr. Rhode explained the basis of his causation opinion and testified that "the patient had…an appropriate injury to his left wrist on September 17, 2015 where he essentially had what we call an axial load to his hand while holding onto a putty knife. He underwent treatment with serial casting for an injury. Once he came out of his casting, he continued to be symptomatic, had on serial exams a positive Finkelstein's maneuver, which reposed to injections. (*Id.*, at 13)

At the hearing Petitioner testified that he is still under the active care of Dr. Rhode. Petitioner testified that he continues to experience numbness, pain, and weakness in his left hand. Petitioner testified that he is currently unemployed and is not to work per Dr. Rhode.

CONCLUSIONS

Petitioner was the sole witness at the hearing in this matter. The Arbitrator found the testimony of the Petitioner to be forthright and credible.

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

Issue (O): Is Respondent entitled to a Section 11 intoxication defense?

Petitioner's unrefuted testimony and the medical evidence consistently document the manner in which Petitioner was injured on September 17, 2015. While each medical history is not identical the Arbitrator does not find the discrepancies significant. Specifically, the Arbitrator finds that as a result of being struck by the Qbits which the forklift set in motion Petitioner was struck of the left elbow forcing his hand into the Qbit on which he was working resulting in an axial load being placed on his arm.

Respondent did not offer any evidence to rebut the medical records and Petitioner's testimony regarding accident. Respondent instead asserts that Petitioner's claim must be denied because he "refused to submit to a drug screen." The Arbitrator finds Respondent's position to be disingenuous.

The unrefuted evidence in the record indicates that the Accident occurred on September 17, 2015. Petitioner reported the accident on the morning of September 18, 2015. At the end of the work day on September 18, 2015 Petitioner was terminated by Respondent as a result of a verbal altercation involving a co-worker. Petitioner testified that he was first requested to return to Respondent's premises to submit to a drug test on September 24, 2015, one week after the accident. Petitioner had sought counsel on September 21, 2015. (see PX1) When contacted on September 24 Petitioner did not refuse to provide a drug test, but simply indicated he had been instructed not to return to Respondent's premises. He was then contacted on September 28th while attending a funeral and again on September 29 at which time he had no transportation. Respondent was to arrange transportation and advise Petitioner of the details, but never did so.

Respondent offered no evidence to refute any of these facts. Instead Respondent asserts that whether Petitioner had his reasons for not complying with Respondents requests that he submit to testing is "simply inapplicable as the Act very clearly provides direction in the matter. That direction in the plain language of the Act forces this Arbitrator to hold no compensation shall be payable if the employee's intoxication is the proximate cause of the employee's accidental injury and further hold that the employee's refusal to submit to testing of blood, breath, or urine, created the rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury."

Section 11 of the Act provides, in pertinent part:

> No compensation shall be payable if (i) the employee's intoxication is the proximate cause of the employee's accidental injury or (ii) at the time the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment. Admissible evidence of the concentration of (1) alcohol, (2) cannabis as defined in the Cannabis Control Act, (3) a controlled substance listed in the Illinois Controlled Substances Act, or

(4) an intoxicating compound listed in the Use of Intoxicating Compounds Act in the employee's blood, breath, or urine at the time the employee incurred the accidental injury shall be considered in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injuries.

If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath, or urine or if there is any evidence of impairment due to the unlawful or unauthorized use of (1) cannabis as defined in the Cannabis Control Act, (2) a controlled substance listed in the Illinois Controlled Substances Act, or (3) an intoxicating compound listed in the Use of Intoxicating Compounds Act or if the employee refuses to submit to testing of blood, breath, or urine, then there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury. The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries. Percentage by weight of alcohol in the blood shall be based on grams of alcohol per 100 milliliters of blood. Percentage by weight of alcohol in the breath shall be based upon grams of alcohol per 210 liters of breath. Any testing that has not been performed by an accredited or certified testing laboratory shall not be admissible in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injury. 820 ILCS 305/11 (emphasis added)

The Act clearly indicates that "the time of the accidental injuries" is the relevant time for determination of intoxication under section 11. In this case the unrefuted evidence indicates that there was no request that Petitioner submit to testing until one week after the date of accident. There would be no probative value in the results of a drug test administered so far removed from the date of accident. Even if Petitioner had submitted to a drug screening one week following the accident which revealed a blood alcohol level in excess of .08% it would not give rise to the presumption that Petitioner was intoxicated at the time of the accident. Section 11 does not allow an employer to demand a drug screening at any random point during the pendency of a claim and then avoid payment of benefits if a claimant fails or refuses testing. In order for the results of or failure to submit to testing to be used to create a presumption of intoxication at the time of the accidental injuries, the testing or refusal must be contemporaneous with the time of injury or sufficiently related in time that there is some probative value to aid in the determination of the critical inquiry of whether the claimant was intoxicated at the time of the injuries.

The Arbitrator concludes that the Petitioner's conduct in this matter, after he had been injured and terminated by Respondent was not tantamount to a refusal to submit to testing. Even if Petitioner had refused to submit to testing one week following the time of injury and thereafter however, the refusal would not give rise to a presumption that Petitioner was intoxicated when he was injured on September 17, 2015.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with

Respondent. The Arbitrator further finds Respondent is not entitled to avoid payment of benefits based upon section 11.

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

Dr. Rhode testified that Petitioner's condition of ill-being was causally related to the accident. Dr. Rhode explained the basis of his causation opinion. The Arbitrator finds Dr. Rhode's testimony and opinions persuasive. Respondent did not offer any evidence to the contrary.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the Petitioner's condition of ill-being to be causally related to the work accident the Petitioner sustained on September 17, 2015.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Petitioner submitted medical expenses totaling $60,024.77. (PX8) Having reviewed the medical records and deposition testimony the Arbitrator finds the medical treatment which Petitioner received was reasonable and necessary. No contrary evidence was submitted. Further having found the unrefuted testimony and opinions of Dr. Rhode to be persuasive, the Arbitrator further finds Petitioner is entitled to prospective medical care.

Respondent shall pay reasonable and necessary medical services of $60,024.77, as set forth in Petitioner's exhibit 8, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further authorize and pay for prospective medical care as recommended by Dr. Blair Rhode, as provided in Sections 8(a) and 8.2 of the Act.

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

Petitioner was terminated by Respondent on September 18, 2015. On that same date OSF placed modified duty restrictions on Plaintiff that included no use of the left hand. On September 22, 2015, Dr. Anane-Sefah placed Petitioner off work and continued to place Petitioner off of work until November 24, 2015. Dr. Rhode either kept Petitioner off of work or on modified duty from December 17, 2015 through the date of hearing, September 18, 2016.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to TTD benefits from September 19, 2015 through November 23, 2015 and from December 17, 2015 through September 18, 2016.

Respondent shall pay Petitioner temporary total disability benefits of $303.83/week for 48 4/7 weeks, commencing 9/19/15 through 11/23/15 (9 2/7 weeks), and 12/17/15 through 9/18/16(39 2/7 weeks), as provided in Section 8(b) of the Act.

Issue (M) Should penalties or fees be imposed upon Respondent?

At the time of Arbitration Respondent indicated that they were provided with the medical bills, in the form of the bills in PX8 for the first time on the date of hearing. The record contains no other evidence to indicate what medical bills, and in what form bills were provided to Respondent prior to the date of hearing. The Arbitrator therefore declines to assess penalties for Respondent's failure to pay medical bills.

With respect to TTD benefits, Respondent's reliance on section 11 as a basis to deny benefits in this case was not reasonable. Respondent also alleges that Petitioner was due no TTD benefits following November 23, 2015 because Dr. Anane-Sefah released Petitioner to return to work without restriction on that date. Although Respondent's assertion in this respect is inaccurate it was at least arguable. The Arbitrator will not say Respondent was unreasonable or vexatious in its denial of benefits for the period following November 23, 2015.

With regard to TTD benefits from September 19, 2015 through November 23, 2015, however Respondent offered no basis for its denial of payment other than its section 11 challenge to accident. Having previously found Respondent's reliance on section 11 in this case disingenuous, the Arbitrator concludes that Respondent's failure to pay TTD benefits from September 19, 2015 through November 23, 2015 was both unreasonable and vexatious.

Section 19(l) provides, in pertinent part:

> If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay.... In case the employer or his or her insurance carrier shall without good and 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.

The record in this matter does not reflect when payment for benefits was first demanded, or when Petitioner first provided Respondent with documentation of work status. The Arbitrator does not have sufficient evidence in the record to calculate the amount of penalties to award pursuant to section 19(l) and therefore declines to make such an award.

What is clear from the record however is that Petitioner was owed TTD benefits in the amount of $303.83 per week for 9 2/7 weeks for the period of September 19, 2015 through November 23, 2015 for a total of $2,821.28.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to Section 19(k) penalties in the amount of $1,410.64, which is equal to 50% of the unreasonably delayed TTD benefits. Under Section 16, the Arbitrator awards attorney fees of $564.26, which is equal to 20% of the unreasonably delayed TTD benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Meyerchick,

Petitioner,

vs.

NO: 16 WC 18737

Aramark Uniform Services,

Respondent.

18IWCC0593

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical, prospective medical, temporary partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2018, 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.

18IWCC0593

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: SEP 28 2018
o092018
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

MEYERCHICK, KENNETH
Employee/Petitioner

Case# **16WC018737**

ARAMARK UNIFORM SERVICES
Employer/Respondent

18IWCC0593

On 3/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% 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:

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
111 W WASINGTON ST SUITE 1800
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) 8(a)

Kenneth Meyerchick
Employee/Petitioner

v.

Aramark Uniform Services
Employer/Respondent

Case # 16 WC 18737

18IWCC0593

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **New Lenox**, on **August 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
D. ☐ 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 ☐ 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 16, 2015** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$72,210.16;** the average weekly wage was **$1,388.83.**

On the date of accident, Petitioner was **57** years of age, **single** with **0** dependent child.

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

Respondent shall be given a credit of $ for TTD, **$36,559.28** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$36,559.28.**

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

ORDER

Medical benefits
Respondent shall pay $396.00 to Dr. Chudik, pursuant to the fee schedule and §8 and §8.2 of the Act.

Prospective Medical benefits
Respondent shall authorize and pay for all reasonable and necessary costs relative to the total left shoulder arthroplasty as prescribed by Dr. Joy and Dr. Chudik, and the associated care, pursuant to the fee schedule and §8 and §8.2 of the Act.

Temporary Partial Disability
Respondent shall pay Petitioner temporary partial disability benefits at the rate of **$352.55** per week for **132-4/7 weeks,** commencing **January 24, 2015 through August 8, 2017.**

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.

Christine MOy
Signature of Arbitrator

March 5, 2018
Date

MAR 6 - 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Meyerchick	)
Petitioner,	)
vs.	) **No. 16 WC 18737**
Aramark Uniform Services	)
Respondent.	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on August 8, 2017. The parties agree: that on January 16, 2015, petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act; that petitioner sustained injuries in an accident that arose out of and in the course of his employment with respondent; that timely notice of the accident was given within the provisions of the Act; that petitioner earned $72,224.45 in the year pre-dating the accident; and that his average weekly wage, calculated pursuant to §10, was $1,388.83.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills
3. Whether petitioner is due temporary partial disability.
4. Whether petitioner is cntitled to prospective medical treatment.

STATEMENT OF FACTS

Petitioner testified he had been employed by respondent as a route sales representative for twelve years as of January 16, 2015. As such, he delivered and sold rubber-nylon floor mats, uniforms, towels, tablecloths and aprons. He was a member of Local 731 Teamsters Union.

He transported the merchandise to the customer by either carrying it or placing it in carts and pushing the carts. He drove a box truck, similar to an UPS truck. His job required him to constantly lift merchandise and push and pull carts. The items he lifted weighed between one pound to fifteen pounds. The carts he pushed and pulled weighed 50 to 60 pounds. He lifted from floor to waist, from floor to shoulder, and also overhead. He had to pull mats off the rails in the truck (PX.10). He worked alone. He needed both arms to perform his job. He is left-handed. Prior to January 16, 2015, petitioner denied having problems with his left arm or having any treatment to it.

On January 16, 2015, petitioner was making a delivery to a customer. He is five foot ten inches tall. The rail on the truck is seven to seven and a half foot tall. Petitioner was removing a four-by-six-foot mat, that weighed ten to fifteen pounds from the rail in the truck. He extended his right arm up 90 degrees and his left arm was extended straight out, palm side up. As he was removing the mat from the rail, he heard a pop in his left shoulder. The pop was where his left arm and shoulder blade came together. He was unable to continuing work. He called his boss, who made the deliveries while petitioner drove the truck.

On the date of the occurrence, petitioner was referred for treatment by respondent to Ingalls Occupational Health facility. Petitioner has not lost any time form work; he has remained on restricted duty under doctor's care. Treatment included physical therapy and a MRI done on February 2, 2015.

He was directed by Sedgwick to Integrity Orthopedics for treatment. He was seen by Dr. Krcik, of Integrity Orthopedics, on February 12, 2015. Dr. Krcik referred him to his associate, Dr. Joy. Dr. Joy recommended injections or surgery. He received treatment by Dr. Joy from February 13, 2015 through June 5, 2015; including physical therapy and injections. The injections did not help. As of the last visit with Dr. Joy on June 5, 2015, Dr. Joy recommended a total shoulder replacement.

Petitioner also underwent a functional capacity evaluation on November 18, 2015.

Petitioner opted to see Dr. Chudik of Hinsdale Orthopedics for a second opinion regarding surgery. This was the first doctor petitioner had chosen himself. Petitioner chose Dr. Chudik at the recommendation of a friend and an internet search. He saw Dr. Chudik on July 16, 2016. Dr. Chudik agreed petitioner was a candidate for a full shoulder replacement. Dr. Chudik kept in place the work restrictions. Petitioner confirmed Dr. Chudik's $389.00 bill remains unpaid.

Petitioner was able to continue working for respondent with an assistant from January 24, 2015 to April 7, 2016 and was paid the correct amount of partial temporary benefits by respondent. After April 8, 2016, petitioner was put on light duty; delivering bar towels to Chicago public schools. He has been paid $860.00 per week since April 8, 2016. Petitioner believes that if he was able to work at full duty, he would still be earning $1,388.83 per week.

Petitioner denied having any new accidents. At respondent's request, petitioner was examined by Dr. Charles Carroll on three different occasions; March 2, 2015, August 7, 2015 and March 3, 2016.

Petitioner is able to use his right arm only to do any of the heavy lifting. His left arm hurts when driving. He has problems taking off and putting on his shirt. He has difficulty washing his right arm with his left arm.

On cross examination, petitioner confirmed respondent's district manager, named Eddie, referred him to Ingalls Occupational Health facility for treatment. Petitioner acknowledged that both Dr. Joy and Dr. Chudik advised the shoulder replacement may not be a 100% fix; nonetheless, he is not able to live with his left arm as it is. He agreed he told Dr. Carroll he had pain off and on for years in his left shoulder. However, he also has had pain in his right shoulder as well; which is fine. He also has pain in his knees off and on, but they are also fine.

On re-direct, petitioner agreed he told Dr. Carroll he had pain off and on in his left shoulder from the work he did, but never sought treatment for the shoulder. Dr. Carroll never asked about his right shoulder which he also had pain off and on; he only inquired as to his left shoulder.

Ingalls Occupational Health Records (PX.1)

Petitioner presented to Ingalls Occupational Health on January 16, 2015 with pain in his left posterior shoulder after pulling a four-by-six-foot mat off the top rail. He was prescribed Naprosyn and Flexeril. The diagnosis was left shoulder pain. He was put on restricted duty. He returned on January 23, 2015 with the same findings and recommendations made. An MRI and physical therapy was ordered. On February 3, 2015, petitioner was referred to an orthopedist.

Ortho/Neuro Evaluation Report (PX.2)

Petitioner was evaluated for 12 sessions of physical therapy.

Physical Therapy Notes (PX.3)

Petitioner received physical therapy from January 27, 2015 through February 10, 2015.

February 2, 2015 MRI Report (PX.4)

There were no tears noted on the MRI, only severe degenerative changes.

Integrity Orthopedics Tinley Park Records (PX.5)

Petitioner was seen by Dr. Krcik on February 12, 2015. Dr. Krcik diagnosed uncontrolled, acute exacerbation of osteoarthritis of the left shoulder; left biceps tendinitis; and left shoulder pain. He was referred to Dr. Joy for further discussion of appropriate treatment of these injuries.

Petitioner saw Dr. Joy on February 13, 2015. Dr. Joy offered an FCE, for permanent restrictions, or total shoulder replacement. He was again seen by Dr. Joy on April 17, 2015; an injection was provided. He saw Dr. Joy again on August 3, 2015 and reported no change from the injection of April, 2015. Dr. Joy recommended a CT scan and total left shoulder replacement. Petitioner did not return to Dr. Joy until March 15, 2016; again Dr. Joy recommended a CT scan and total left shoulder replacement.

Petitioner remained on restricted work during the period he was under the care of the Integrity Orthopedists.

Integrity Physical Therapy and Rehabilitation Records (PX.6)

The May 5, 2015 and May 28, 2015 evaluations indicated petitioner did not improve with physical therapy.

Hinsdale Orthopaedics Medical Records (PX.7)

Petitioner was seen by Dr. Chudik on July 6, 2016. Based upon his examination and petitioner's history, Dr. Chudik reported petitioner had left shoulder glenohumeral arthritis that requires total shoulder arthroplasty.

Dr. Steven Chudik November 22, 2016 Report (PX.8)

In his November 22, 2016 report to petitioner's counsel, Dr. Chudik opined that petitioner's left shoulder condition, which now requires total shoulder replacement, was caused by the work injury of January 16, 2015. Dr. Chudik made this determination despite the existence of the pre-existing glenohumeral arthritis, as petitioner received no treatment and was managing the pre-existing arthritis until the work accident of January 16, 2015. On January 16, 2015, petitioner suffered an aggravation of the pre-existing condition, that has not improved with conservative treatment including injections and physical therapy, and now requires a total shoulder replacement.

Work Strategies November 18, 2015 Functional Capacity Evaluation [FCE] Report (PX.9)

According to the FCE, petitioner's physical demand level was at the medium work level which is exerting up to 25 to 50 pounds.

Mat and Rail Photo (PX.10)

Petitioner identified the photo as that which depicted the rail and the mat that was involved in the work accident.

Hinsdale Orthopaedics Bill (PX.11)

Dr. Chudik's July 6, 2016 bill in the amount of $389.00 remains outstanding.

Dr. Steven Chudik May 22, 2017 Deposition (PX.12)

Dr. Steven Chudik, board certified orthopedic surgeon with subspecialties in sports medicine and shoulder surgery, testified in behalf of petitioner.

Dr. Chudik examined petitioner on July 6, 2016 and generated a record of the visit (16-17). Petitioner reported the injury to his left shoulder approximately 18 months before while lifting a rug out of his truck at work. He denied having prior injury or treatment to his left shoulder before the incident at work. Petitioner had undergone physical therapy and injections which failed to improve his condition. (16-17)

Dr. Chudik's examination revealed tenderness over the shoulder A/C joint; passive elevation was significantly decreased, as well active elevation. Petitioner had weakness and pain on abduction and internal rotation, and a positive Hawkins test; a non-specific test for pain. (18)

Dr. Chudik's diagnosis was symptomatic left shoulder glenohumeral arthritis (19). This diagnosis was consistent with both the subjective and objective findings (19-20). Based upon the findings and diagnosis, Dr. Chudik recommended a total shoulder arthroplasty (20). After weighing the risks to the benefits, Dr. Chudik felt the total shoulder arthroplasty was the best treatment option, given petitioner's age, symptoms and the effect the condition was having on petitioner's way of life (20-22).

Dr. Chudik testified there was a causal connection between the findings of his exam on July 6, 2016 to the accident of January 16, 2015, as petitioner was asymptomatic and capable of working at full capacity until the accident of January 16, 2015 that aggravated his pre-existing arthritis (24-25). Dr. Chudik believed this was a permanent aggravation as documented by the functional capacity evaluation and Dr. Carroll's findings (25-26). Dr. Chudik's review of the February 2, 2015 MRI showed there was fluid in the glenohumeral joint which indicated a recent aggravation and swelling or recent injury (26-27).

Dr. Chudik reviewed the photo of the truck and rug, as identified in Petitioner Exhibit 10, and agreed that how the injury occurred based upon the photo and the description of injury provided, was consistent with petitioner's history to Dr. Chudik (30-31).

Dr. Chudik agreed with Dr. Carroll's assessment that petitioner injured his shoulder, requiring treatment; that petitioner's injury has restricted petitioner from doing his regular job; that he had permanent limitations as defined by the FCE; that all treatment to date was appropriate; and that petitioner may require a total shoulder replacement (39). Dr. Chudik disagreed with Dr. Carroll's diagnosis of the work injury as only a rotator cuff strain (40). Dr. Chudik also disagreed with Dr. Carroll's assessment that the aggravation of the arthritis was only temporary (40). Dr. Chudik confirmed petitioner had not returned to his pre-injury status (41).

On cross-examination, Dr. Chudik agreed that if the petitioner did not want to undergo the total shoulder replacement because of the risks involved, then an FCE was an option as indicated by Dr. Joy in his March 15, 2015 record (42-44). Dr. Chudik believed the petitioner may have some restrictions even with the replacement; and that the prosthetic has a life-expectancy of between 15 and 20 years (49-52).

Dr. Charles Carroll March 2, 2015 Report (RX.1)

Petitioner was first examined by Dr. Charles Carroll on March 2, 2015. Dr. Carroll believed petitioner sustained a left shoulder strain and probable rotator cuff impingement which

may be related to the work accident. Dr. Carroll recommended corticosteroid injection and four weeks of therapy for this condition. Dr. Carroll also thought petitioner may need subacromial decompression for this condition.

Dr. Carroll also noted petitioner had pre-existing arthritis that was not related to the work injury.

Dr. Charles Carroll August 7, 2015 Report (RX.2)

Petitioner returned to Dr. Carroll on August 7, 2015 after undergoing four weeks of physical therapy. Dr. Carroll's findings and opinions remain the same as expressed at the time of his exam on March 2, 2015; which was a rotator cuff strain that was related to the work accident. Dr. Carroll again found the arthritis was not related to the work accident; hence, the need for the arthroplasty was not related to the work accident.

Dr. Carroll recommend an FCE which would place petitioner at maximum medical improvement.

Dr. Charles Carrol December 31, 2015 Report (RX.3)

Dr. Carroll authored this report after reviewing the valid November 18, 2015 functional capacity evaluation. Dr. Carroll agreed with petitioner's work restrictions as outlined in the functional capacity evaluation.

Dr. Carroll's opinion regarding the arthritis not being related to the work accident remained the same.

Dr. Charles Carroll March 3, 2016 Report (RX.4)

Dr. Carroll re-examined petitioner on March 3, 2016. He found petitioner had reached maximum medical improvement from the work injury, which he believed was a strain of the left shoulder. Dr. Carroll believed petitioner had restrictions. Dr. Carroll again did not find the need for the total shoulder replacement due to arthritis was related to the work accident.

Dr. Charles Carroll March 31, 2016 Report (RX.5)

Dr. Carroll authored this report after reviewing medical records. Dr. Carroll believed at this time that petitioner's restrictions were the result of the non-related arthritis and not the shoulder strain from the work accident.

Dr. Charles Carroll March 10, 2017 Report (RX.6)

Dr. Carroll authored this report after reviewing Dr. Chudik's November 22, 2016 report and Dr. Chudik's records. After reviewing these records, Dr. Carroll remained steadfast in his opinion that the need for the total should arthroplasty was related to the underlying arthritis and not related to the work injury strain. Dr. Carroll also recommended petitioner go slow with the total shoulder replacement.

Dr. Charles Carroll July 17, 2017 Deposition (RX.7)

Dr. Carroll, board certified orthopedic and hand surgeon, testified in behalf of respondent. Dr. Carroll's testimony was consistent with the opinions he expressed in his reports identified as Respondent Exhibits 1 through 6.

At the time of his initial exam on March 2, 2015, based upon his review of the diagnostic films, Dr. Carroll did not believe the arthritis was caused or aggravated by the work accident (12).

Dr. Carroll recommended physical therapy and an injection for the diagnosed strain from the work accident (13). Dr. Carroll believed petitioner's restrictions were the result of both the pre-existing arthritis and the work-related strain (13). As of the first exam on March 2, 2015, Dr. Carroll did not believe petitioner had reached maximum medical improvement; and likely would not for another six months (14).

On December 31, 2015, Dr. Carroll determined petitioner was restricted in accordance with the November 18, 2015 FCE, which was the result of both the arthritis and the strain (19-21).

Dr. Carroll testified that as of his March 2, 2016, petitioner had reached maximum medical improvement from the work-injury strain, but did not state petitioner had recovered from the strain injury (22-24).

On cross-examination, Dr. Carroll confirmed that the restrictions outlined in the November 18, 2015 were permanent (57).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator makes the following conclusions of law:

Based upon the evidence, which included petitioner's testimony and all of the medical evidence, the Arbitrator finds petitioner's glenohumeral arthritis of the left shoulder was permanently exacerbated by the work accident of January 16, 2015.

The medical evidence considered by the Arbitrator in reaching this conclusion was: the records from Ingalls Occupational Health, where petitioner was sent by respondent, that included a history of left shoulder pain ensuing after the work accident; Integrity Orthopedics Tinley Park records, where petitioner was sent by the insurance adjuster with Sedgwick, which included those of Dr. Krcik, who opined petitioner had an acute exacerbation of the osteoarthritis of the left shoulder, and those of Dr. Joy, to whom petitioner had been referred by Dr. Krcik for treatment of the left shoulder injury diagnosed by Dr. Krcik; and Dr. Chudik of Hinsdale Orthopaedics, who found petitioner's pre-existing glenohumeral arthritis was manageable and not in need of treatment until the work accident of January 16, 2015.

The Arbitrator further finds that the permanent exacerbation of the arthritis restricts the petitioner from performing his regular employment with respondent and requires a total shoulder replacement.

In reaching this conclusion, the Arbitrator considered the fact that petitioner was able to perform his full-duty responsibilities with respondent for twelve years, which required him to constantly lift, carry, push and pull, despite the existence of the pre-existing condition, until the work accident. Thereafter, all physicians determined petitioner had permanent work restrictions. The legal analysis of "chain of events", as set forth in *Ill. Power co. v. Industrial Comm'n.*, 176 Ill.App.3d 317, 530 N.E.2d 617 (4th Dist. 1988), supports this determination.

The Arbitrator reached this conclusion despite the opinion of Dr. Carroll, who refused to acknowledge petitioner's arthritis was in any way aggravated by the work accident. Dr. Carroll agreed petitioner had sustained a strain/impingement of the rotator cuff as a result of the work accident, but did not agree the accident aggravated the pre-existing arthritis.

Dr. Carroll agreed that as late as December 31, 2015, petitioner had permanent restrictions, as determined by the FCE of November 18, 2015, and that the permanent restrictions were the result of both the pre-existing arthritis and the strain. And yet, despite petitioner not receiving any

further treatment after the November 18, 2015 FCE, Dr. Carroll determined at the time of his March 3, 2016 exam, petitioner had no restrictions from the work accident; the restrictions were the result of the pre-existing arthritis. Furthermore, as of March 2, 2016, Dr. Carroll fell short of stating petitioner had recovered from even the strain injury; only stating petitioner had reached maximum medical improvement (RX.7, pp.23-24).

The Arbitrator followed the legal precedence as set forth in *International Vermiculite Company v. Industrial Comm'n*, 77 Ill.2d 1, 394 N.E.2d 1166 (1979) and *Edgcomb v. Industrial Comm'n.*, 181 Ill. App. 3d 398 (1989) in giving more weight to petitioner's treating physicians' opinions.

J. With respect to the issue regarding medical bills, the Arbitrator makes the following conclusions of law:

The Arbitrator, having found in favor of petitioner on the issue of causal connection, awards the bill for services rendered by Dr. Chudik on July 6, 2016 in the amount of $389.00, pursuant to the fee schedule and §8 and §8.2 of the Act.

K. With respect to the issue regarding prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator, having found on the issue of causality, awards the costs of the total left shoulder arthroplasty, and associate care. Although at the time of his exams, Dr. Carroll did not believe petitioner was at the point the shoulder replacement was necessary, regardless of the cause, he did not rule it out in the future.

Therefore, the Arbitrator awards the costs of the total left shoulder arthroplasty, and the associate care; to be authorized and paid by respondent in accordance with the fee schedule and §8 and §8.2 of the Act.

L. With respect to the Arbitrator's decision with regard to temporary partial disability, the Arbitrator makes the following conclusions of law:

The Arbitrator finds petitioner's ongoing disability, resulting in a reduction of earnings, was caused by the work accident, and awards petitioner temporary partial disability for the full period from January 24, 2015 through the date of hearing on August 8, 2017. As petitioner would be earning $1,388.83 per week in full performance of his job, and now is only able to earn $860.00 per week as a result of the injury, he is entitled to $352.55 per week for the period from January 24, 2015 through the date of hearing on August 8, 2017, which is 132-3/7 weeks, in accordance with §8 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 PEORIA)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jaysen Hamann,
Petitioner,

vs. NO: 15 WC 08493

Keystone Steel & Wire.
Respondent.

18IWCC0594

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed November 15, 2016 is hereby affirmed and adopted.

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

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

DATED: SEP 28 2018

Joshua D. Luskin

Charles J. DeVriendt

o-08/01/18
jdl-wj
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18IWCC0594

SPECIAL CONCURRING OPINION

I concur with the result reached by the majority. I write separately to further expand on the analysis.

Petitioner testified he was walking outside with a co-worker, Mike Pagan, when he slipped on ice in a tire rut. T. 30. Petitioner confirmed Mr. Pagan was walking in front of him when the incident occurred. T. 28; 83. Petitioner testified he spoke with Mr. Barker after the incident occurred but could not recall the particulars of the conversation. T. 84-85.

Mr. Robert Chester Barker testified on behalf of Respondent. Mr. Barker testified he has worked for Respondent for 18 years and is currently the senior safety and health specialist. T. 100-01. Mr. Barker testified he met with Petitioner at the plant medical facility and discussed the incident immediately after its occurrence. T. 102. Mr. Barker explained he questioned Petitioner on how the incident occurred, and Petitioner advised he was not sure and thought he might have hydraulic fluid on his shoe. T. 104. Mr. Barker testified that same day, he investigated the area where Petitioner claimed he slipped and found no ice. T. 107. On cross-examination, Mr. Barker agreed it was cold, and he did not observe any ruts made by tires. T. 110. Mr. Pagan was not called to testify by either party.

Petitioner completed an accident report indicating he slipped on ice. RX6. The history was recorded in Respondent's report of injury or illness. RX5. When Petitioner presented to Prairie Spine and Pain Institute on March 5, 2015, he provided a history of slipping on ice and being caught by his co-worker. PX7.

I agree with the arbitrator's assessment that Petitioner was not credible. I find Mr. Barker's testimony credible. Mr. Barker testified he investigated the area where Petitioner allegedly slipped and found no tire ruts nor any ice. There is simply no hazard present. The Petitioner may have slipped, but there is no credible evidence it was caused by an employment risk or hazard.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAMANN, JAYSEN
Employee/Petitioner

Case# **15WC008493**

KEYSTONE STEEL & WIRE
Employer/Respondent

18IWCC0594

On 11/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% 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:

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0507 RUSIN & MACIOROWSKI LTD
JOHN A 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

Jaysen Hamann
Employee/Petitioner

v.

Keystone Steel & Wire
Employer/Respondent

Case # 15 WC 08493

Consolidated cases: n/a

18IWCC0594

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on October 14, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On March 2, 2015, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $92,040.00; the average weekly wage was $1,770.00.

On the date of accident, Petitioner was 39 years of age, married with 1 dependent child(ren).

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 $15,878.57 for other benefits, for a total credit of $15,878.57.

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

ORDER

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

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

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

William R. Gallagher

William R. Gallagher, Arbitrator

November 8, 2016

Date

ICArbDec p. 2

NOV 15 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on March 2, 2015. According to the Application, Petitioner "Slipped and fell and twisted" and sustained injuries to the "Low back, left side, left arm and whole person" (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship. (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in April, 2013, as a Mechanical Technician. Petitioner performed various maintenance duties throughout Respondent's plant. Respondent is in the business of manufacturing steel wires and rods.

Petitioner testified that on March 2, 2015, he was walking with another employee, Mike Pagan, in an area of the plant that housed various pieces of equipment, tractors, bulldozers, etc. Petitioner was walking on a concrete surface; however, the surface had numerous ruts and potholes. Because of the cold temperature, there was an accumulation of ice on the surface, in particular, in the ruts and potholes.

Petitioner testified that while he was in the process of walking on the ice covered surface, he slipped on the ice and sustained a twisting type injury to his low back. However, Petitioner did not fall to the ground. Petitioner reported the accident to Respondent and was directed to go to the plant medical facility. On May 4, 2015, Petitioner prepared a written description of the accident in which he stated that he caught his balance, did not fall, but "severely twisted" his low back (Petitioner's Exhibit 2).

Petitioner was seen by Dr. Homer Pena on March 2, and March 3, 2015. On March 2, Petitioner informed Dr. Pena that he slipped on ice, but caught himself before falling. On examination, Petitioner complained of pain, but there was no muscular spasm. Dr. Pena described Petitioner's condition as low back pain without objective findings (Petitioner's Exhibit 5).

When Dr. Pena saw Petitioner the following day, March 3, 2015, he again noted the absence of any positive objective findings. Dr. Pena released Petitioner to return to work without restrictions effective March 4, 2015 (Petitioner's Exhibit 5).

Petitioner subsequently retained counsel to represent him (the date on the Application was March 5, 2015), and he went to the ER of Pekin Hospital on March 3, 2015. When seen in the ER, Petitioner complained of low back pain of 8/10. X-rays were taken of the lumbar spine which revealed some degenerative changes, in particular, at the L5-S1 level. Petitioner was diagnosed with a lumbosacral strain and discharged (Petitioner's Exhibit 4).

Petitioner then sought treatment at Prairie Spine and Pain Institute on March 5, 2015. At that time, a new patient form was completed which, among other things, described the accident. According to the form, Petitioner slipped on ice, jolted back and a "...coworker caught him." Petitioner signed this form (Petitioner's Exhibit 7; Respondent's Exhibit 8).

Petitioner was seen at Prairie Spine and Pain Institute by Derek Morrow, a Physician's Assistant, on March 5, 2015. According to PA Morrow's record of that date, Petitioner informed him that he slipped on a sheet of ice at work. The record noted that when Petitioner slipped, "His coworker, who was standing right next to him, caught him as he started to slip backward." (Petitioner's Exhibit 7).

PA Morrow examined Petitioner and noted that he had signs of radiculopathy on the left side. He opined that Petitioner had a sensory deficit consistent with and L4 dermatome. He ordered an MRI scan (Petitioner's Exhibit 7).

The MRI was performed on March 9, 2015. The radiologist noted a past right L5-S1 laminectomy with advanced degenerative changes at that level. He also opined that there were no recurrent or new disc herniations (Petitioner's Exhibit 6).

Petitioner was later seen by Dr. Richard Kube, an orthopedic surgeon, on March 17, 2015. Dr. Kube examined Petitioner and reviewed both PA Morrow's record and the MRI scan. Dr. Kube opined that Petitioner's findings were more consistent with a left L5-S1 disc protrusion. He opined that it was possible that the injury aggravated or created the disc protrusion. He recommended Petitioner have an epidural steroid injection (Petitioner's Exhibit 7).

Dr. Kube administered an epidural steroid injection at L4-L5 and L5-S1 on March 23, 2015. He administered another epidural steroid injection at L5-S1 on April 27, 2015 (Petitioner's Exhibits 8 and 9).

Petitioner received physical therapy in March and April, 2015. According to the physical therapy record of March 25, 2015, the epidural steroid injection did not give Petitioner any relief of his symptoms. The record of April 17, 2015, noted that Petitioner's pain had increased due to his mowing his yard (Respondent's Exhibits 9 and 10).

At the direction of Respondent, Petitioner was examined by Dr. Julie Wehner, an orthopedic surgeon, on April 1, 2015. In connection with her examination of Petitioner, Dr. Wehner reviewed medical records for the treatment Petitioner received shortly after the accident which included the report of the MRI. Dr. Wehner's clinical examination of Petitioner revealed no positive objective findings and she described it as normal. She also opined that the MRI only revealed the prior right L5-S1 laminectomy and disc space degeneration at that level but no recurrent disc herniation on the left. She opined Petitioner could return to work and that no further treatment was indicated (Respondent's Exhibit 12; Deposition Exhibit 1).

Petitioner continued to be treated by PA Morrow and Dr. Kube. When Dr. Kube saw Petitioner on May 7, 2015, he recommended Petitioner undergo fusion surgery at L5-S1 (Petitioner's Exhibit 7).

At the request of Respondent, Dr. Wehner reviewed additional medical records provided to her by Respondent and prepared a supplemental report dated June 12, 2015. Dr. Wehner noted that when Petitioner was seen by Dr. Pena and in the ER of Pekin Hospital, there were no positive objective findings. She also restated her opinion that the MRI did not reveal any recent or new

disc herniations. Dr. Wehner opined that Petitioner's clinical and radiographic findings did not correlate with the severity of his complaints. She also opined that fusion surgery was not indicated and restated her opinion that Petitioner was at MMI and could return to work without restrictions (Respondent's Exhibit 12; Deposition Exhibit 2).

Again at the request of Respondent, Dr. Wehner reviewed MRIs of Petitioner's lumbar spine obtained on March 16, 2002, December 12, 2003, February 28, 2005, August 26, 2006, and March 9, 2015. She again noted that the MRI of March 9, 2015, did not reveal any acute findings and that none of her prior opinions she had expressed about the need for fusion surgery, Petitioner being at MMI or ability to return to work had changed (Respondent's Exhibit 12; Deposition Exhibit 3).

Petitioner continued to be treated by Dr. Kube who performed fusion surgery on July 27, 2015. The procedure consisted of a decompression and fusion at L5-S1 with both metal hardware and bone grafting (Petitioner's Exhibit 10). Dr. Kube also performed sacroiliac joint injections on both November 9, 2015, and December 14, 2015 (Petitioner's Exhibits 11 and 12). Petitioner continued to be seen by Dr. Kube and was released return to work without restrictions effective February 2, 2016 (Petitioner's Exhibit 7).

Again, at the direction of Respondent, Dr. Wehner examined Petitioner on May 11, 2016. In connection with her examination of Petitioner, she reviewed up to date medical records regarding Petitioner's treatment including the fusion surgery. Dr. Wehner opined that the fusion surgery was not indicated. She further stated that the mechanics of the alleged injury did not produce any anatomical changes in Petitioner's spine. Dr. Wehner did performed an AMA impairment rating evaluation and opined to a rating of eight percent (8%) (Respondent's Exhibit 12; Deposition Exhibit 4).

Dr. Kube was deposed on April 28, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Kube's testimony regarding his diagnosis and treatment of Petitioner was consistent with his medical records. When he testified about the history Petitioner had provided to him, he stated that when Petitioner started to fall, a coworker was standing next to him and caught him as he started to fall backwards. When Dr. Kube was question about causality, he testified that the mechanism of injury of March 2, 2015, could have aggravated the degenerative disease process in Petitioner's low back (Petitioner's Exhibit 14; pp 11, 45-46).

On cross-examination, Dr. Kube agreed that his opinion regarding causality relied upon the accuracy of the history that Petitioner sustained some type of slip and twist. He further opined that he could not state that the findings noted in the MRI of March, 2015, in regard to L5-S1, had changed in any way than what they were prior to March 1, 2015. He also acknowledged that there were no objective findings on examination (Petitioner's Exhibit 14; pp 77-78).

Dr. Wehner was deposed on June 3, 2016, and her deposition testimony was received into evidence at trial. On direct examination, Dr. Wehner's testimony was consistent with her medical reports and she reaffirmed the opinions contained therein. Specifically, Dr. Wehner noted that

the operative report of the fusion did not reveal a herniated disc, but only some scar tissue that was not related to the accident of March 2, 2015 (Respondent's Exhibit 12; pp 28-29).

Petitioner testified that he was able to return to his regular job for Respondent. While Dr. Kube authorized Petitioner to return to work on February 2, 2016, Petitioner was required by Respondent to undergo a physical examination before being permitted to do so. He underwent exam and he was released to return to work on February 7, 2016. At trial, Petitioner had minimal complaints and said that his back felt "good." On cross-examination, Petitioner agreed that the coworker, Mike Pagan, was walking in front of him at the time of the accident. When questioned about the history in some of the medical records about his being caught by another employee, Petitioner agreed that this was not accurate and was, in fact, impossible because Pagan was walking in front of him.

On cross-examination, Petitioner was also questioned about a number of other workers' compensation cases that he has had for which he has received settlements. Petitioner acknowledged that he sustained an injury to his low back on September 15, 2001, which required back surgery and that he settled the case for over $100,000. The Commission record of that settlement was received into evidence and it indicated that Petitioner received a settlement of $102,143.86 (Respondent's Exhibit 1).

Petitioner subsequently acknowledged having sustained a work-related injury to his back and hip for which he received a settlement of $55,000. The Commission record of that settlement was also received into evidence at trial (Respondent's Exhibit 2).

Petitioner again acknowledged having sustained another work-related injury to a shoulder for which he received a settlement of $50,000. The Commission record of that settlement was also received into evidence (Respondent's Exhibit 3).

Finally, Petitioner acknowledged having a common law action against Power Maintenance Contractors for an accident that occurred on May 26, 2009. When questioned whether he had received a settlement of $100,000, Petitioner stated he could not recall.

At trial, Robert Barker testified on behalf of the Respondent. Barker was the Respondent's senior safety/health specialist. Barker said that one of his job duties was investigating work-related accidents. Barker stated that he saw Petitioner on March 2, 2015, at the plant medical facility. At that time, Petitioner informed him that he may have had an accumulation of hydraulic fluid on his shoes and that is what caused him to fall. He described Petitioner as acting in a completely normal manner until he was presented with a pain diagram to fill in at which time Petitioner complained of severe back pain. Further, Barker observed the area where the accident occurred and did not see an accumulation of ice. Barker also stated that he had discussed the accident with Mike Pagan and that there was no evidence that Petitioner had, in fact, sustained an injury.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on March 2, 2015.

In support of this conclusion the Arbitrator notes the following:

There were inconsistencies in the history of the accident given by Petitioner to the medical providers and to Robert Barker.

As noted herein, Petitioner informed Dr. Pena that he slipped on ice and sustained a twisting injury to his low back. There was no reference to Petitioner having been caught by another employee.

When Petitioner was evaluated at Prairie Spine and Pain Institute, he signed a patient information sheet and informed both PA Morrow and Dr. Kube that he slipped on ice and that a coworker had caught him.

At trial, Petitioner agreed that the coworker, Mike Pagan, who was present at the time of the accident was walking in front of him and that it would have been impossible for him to have caught Petitioner.

When Petitioner spoke to Robert Barker at the plant medical facility shortly after the accident, he told him that he thought he slipped because of an accumulation of hydraulic fluid on his shoes.

When examined by Dr. Pena and Dr. Wehner, there were no positive objective findings on clinical examination. Even Petitioner's treating physician, Dr. Kube, agreed that there were no positive objective findings on clinical examination.

Petitioner has had a significant history of sustaining work-related injuries for which he has received settlements in excess of $200,000.

Based upon the preceding, the Arbitrator finds Petitioner's credibility to be suspect.

In regard to disputed issues (F), (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 issue (C).

William R. Gallagher, Arbitrator